



Medicaid EHR Incentive Program

Eligible Hospital Meaningful Use Attestation Manual

Program Year 2015



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1 Program Overview

1.1 Introduction

The Kentucky Medicaid Electronic Health Record (EHR) Incentive Program provides incentive payments to eligible professionals (EPs), eligible hospitals (EHs) and critical access hospitals (CAHs) as they adopt, implement, upgrade (AIU) or demonstrate meaningful use (MU) of certified EHR technology. The purpose of this document is to provide instructions for providers to complete attestation for the Kentucky Medicaid EHR Incentive Program using the KYSLR system.

Resources:

- 42 CFR Parts 412, 413, 422 et al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program Final Rule located at <http://www.gpo.gov/fdsys/pkg/FR-2010-07-28/pdf/2010-17207.pdf>
- 42 CFR Parts 412 and 495 et al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program - Stage 3 and Modifications to Meaningful Use in 2015 Through 2017; Final Rule located at <http://chfs.ky.gov/NR/rdonlyres/9C13A6FE-199F-44F6-8C78-402E3BBCFECE/0/ModandStage3FinalRule.pdf>
- Kentucky State Medicaid HIT Plan (SMHP) Version 1.1 located at <http://chfs.ky.gov/dms/EHR.htm>
- Kentucky Medicaid EHR Application Portal located at <https://prdweb.chfs.ky.gov/KYSLR/Login.aspx>
- Medicare and Medicaid Electronic Health records (EHR) Incentive Program located at <http://www.cms.gov/EHRIncentivePrograms/>
- Office of the National Coordinator for Health Information Technology located at <http://healthit.gov/>
- Kentucky Health Information Exchange located at <http://khie.ky.gov/Pages/index.aspx>

Regional Extension Centers (RECs) have been designated to provide technical assistance to Kentucky providers. The RECs provide a full range of assistance related to EHR selection and training are listed below:

- Northeast Kentucky Area
NorthEast Kentucky Regional Information Organization (NeKY RHIO)
Website: <http://www.nekyrhio.org/>
Phone: 855-385-2089
E-mail: admin@nekyrhio.org
- Remaining Areas of Kentucky
Kentucky Regional Extension Center
Website: <http://kentuckyrec.com/>
Phone: 888-KY-REC-EHR or 859-323-3090
E-mail: kyrec@uky.edu

1.2 Background

The Centers for Medicare & Medicaid Services (CMS) has implemented, through provisions of the American Recovery and Reinvestment Act of 2009 (ARRA), incentive payments to EPs and EHs, including CAHs participating in Medicare and Medicaid programs that are meaningful users of certified EHR technology. The incentive payments are not a reimbursement, but are intended to encourage EPs and EHs to adopt, implement, or upgrade certified EHR technology and use it in a meaningful manner.

Use of certified EHR systems is required to qualify for incentive payments. The Office of the National Coordinator for Health Information Technology (ONC) has issued rules defining certified EHR systems and has identified entities that may certify systems. More information about this process is available at <http://www.healthit.gov>.

Goals for the national program include: 1) Improve the quality, safety, and efficiency of care while reducing disparities 2) Engage patients and families in their care 3) Promote public and population health 4) Improve care coordination and 5) Promote the privacy and security of patient information. Achieving these goals will improve health outcomes, facilitate access, simplify care and reduce costs of health care nationwide.

The Kentucky Department for Medicaid Services (DMS) works closely with federal and state partners to ensure the Kentucky Medicaid EHR Incentive Program fits into the overall strategic plan for the Kentucky Health Information Exchange (KHIE), thereby advancing national and Kentucky goals for HIE.

Both EH and CAHs are required to begin by registering at the national level with the Medicare and Medicaid registration and attestation system (also referred to as the NLR). CMS' official Web site for the Medicare and Medicaid EHR Incentive Programs can be found at <http://www.cms.gov/EHRIncentivePrograms/>. The site provides general and detailed information on the programs, including tabs to guide users on the path to payment, eligibility, meaningful use, certified EHR technology, and frequently asked questions.

1.3 Overview of Changes for Program Year 2015

On October 16, 2015, CMS released a Final Rule that specifies criteria for participating in the Medicare and Medicaid EHR Incentive Programs for 2015 through 2017 (Modified Stage 2) as well as Stage 3 in 2018 and beyond. The EHR Incentive Programs in 2015 through 2017 (Modified Stage 2) reflect changes to the objectives and measures of Stages 1 and 2 to align with Stage 3, which focuses on the advanced use of EHRs. The changes also aim to reduce the complexity of the program and work toward a shift to a single set of sustainable objectives and measures in 2018. Redundant, duplicative, or topped out measures have been removed.

Starting in 2015, all providers will be required to attest to a single set of objectives and measures. Since this change may occur after providers have already started to work toward meaningful use in 2015, there are alternate exclusions and specifications within individual objectives for providers who were previously scheduled to be in Stage 1 of the EHR Incentive Programs.

In response to public comments, two patient engagement objectives that involve patient action have also been modified for 2015 through 2017. The public health reporting objectives have been consolidated into one objective with measure options, which aligns with the structure of Stage 3.

CMS Key Concepts for the EHR Incentive Programs in 2015 through 2017 (Modified Stage 2)

Restructured Stage 1 and Stage 2 objectives and measures to align with Stage 3: 9 objectives for EHs and CAHs, including one consolidated public health reporting objective with 4 measure options.

- Starting in 2015, the EHR reporting period aligns with the calendar year for all providers.
- Changed the EHR reporting period in 2015 to 90 days to accommodate modifications to meaningful use.
- May select an EHR reporting period of any continuous 90-day period from October 1, 2014 to December 31, 2015.
- EHR technology must be certified to the 2014 Edition.
- Modified Stage 2 patient engagement objectives that require “patient action”.
- Streamlined the program by removing redundant, duplicative, and topped out measures.
- CQM reporting remains as previously finalized.

To allow CMS and providers time to implement these modifications, the EHR reporting period in 2015 is any continuous 90 day period within the calendar year. All providers will have until May 31, 2016 to attest for program year 2015.

2 Eligibility

While EHs and CAHs could begin the program in Calendar Year (CY) 2013, they must begin the program no later than CY 2016.

The first tier of provider eligibility for the program is based on provider type and specialty. If the provider type and specialty for the submitting provider in the KY MMIS provider data store **does not** correspond to the provider types and specialties approved for participation in the Kentucky Medicaid EHR Incentive Program, the provider will receive an error message with a disqualification statement.

At this time, CHFS DMS has determined that the following providers are potentially eligible to enroll in the Kentucky Medicaid EHR Incentive Program:

- Acute Care Hospital = Any provider with a Provider Type 01 and Specialty 010
- Children’s Hospital = Any provider with a Provider Type 01 and Specialty 015
- CAH = Any provider with a Provider Type 01 and Specialty 014

2.1 Additional Requirements for the EH/CAH

To qualify for an EHR incentive payment for each year the EH seeks the incentive payment, the EH must be one of the following:

- An acute care hospital (includes CAH) that has at least a 10 percent Medicaid patient volume for each year the hospital seeks an EHR incentive payment; or

- A children’s hospital (exempt from meeting a patient volume threshold).
- Hospital-based providers are not eligible for the EHR incentive program.

Qualifying Providers by Type and Patient Volume

| Program Entity | Percent Patient Volume over Minimum 90-days |
|---------------------|--|
| Acute Care Hospital | 10% |
| Children’s Hospital | Patient Encounter definition expanded to include TXXI-CHIP encounters (but not separate CHIPs) |

2.2 Out-of-State EH/CAHs

The Kentucky Medicaid EHR Incentive Program welcomes out-of-state EH/CAHs to participate in this program as long as they have at least one physical location in Kentucky. Kentucky must be the only state they are requesting an incentive payment from during that participation year. For audit purposes, out-of-state EH/CAHs must make available any and all records, claims data, and other data pertinent to an audit by either the Kentucky DMS program or CMS. Records must be maintained as applicable by law in the state of practice or Kentucky, whichever is deemed longer.

2.3 Establishing Patient Volume

An EH/CAH must annually meet patient volume requirements to participate in Kentucky’s Medicaid EHR Incentive Program as established through the state’s CMS approved State Medicaid Health IT Plan (SMHP). The patient funding source identifies who can be counted in the patient volume: Title XIX (TXIX) – Medicaid and Title XXI (TXXI) – CHIP (but not separate CHIPs). All EH/CAHs should calculate patient volume based on TXIX - Medicaid and/or TXXI-CHIP and out-of-state Medicaid patients.

2.3.1 Patient Encounters Methodology

To calculate TXIX DMS patient volumeThe total TXIX DMS and out-of-state Medicaid encounters in any representative 90-day period in the preceding fiscal year OR the preceding 12 months by:

- The total encounters in the same 90-day period.
- Total number of inpatient bed days for all discharges in a 90-day period (even if some of those days preceded the 90-day range) plus total number of emergency department visits in the same 90-day period. *(Please note per CMS FAQ nursery days are excluded from inpatient bed days)*
- An emergency department must be part of the hospital.

2.3.2 DMS Encounter Definition

For purposes of calculating eligible hospital patient volume, a DMS encounter is defined as services rendered to an individual 1) per inpatient discharge, or 2) on any one day in the

emergency room where TXIX and TXXI-CHIP DMS (but not separate CHIPs) or another state's Medicaid program paid for :

- Part or all of the service;
- Part or all of their premiums, co-payments, and/or cost-sharing;

3 Payment Methodology

Statutory parameters placed on Kentucky Medicaid incentive payments to hospitals are largely based on the methodology applied to Medicare incentive payments. The specifications described in this section are limits to which all states must adhere when developing aggregate EHR hospital incentive amounts for Medicaid-eligible hospitals. States will calculate hospital aggregate EHR hospital incentive amounts on the FFY to align with hospitals participating in the Medicare EHR incentive program.

Children's hospitals and acute care hospitals may be paid up to 100 percent of an aggregate EHR hospital incentive amount provided over a three-year period. Section 1905(t)(5)(D) requires that no payments can be made to hospitals after 2016 unless the provider has been paid a payment in the previous year; thus, while Medicaid EPs are afforded flexibility to receive payments on a non-consecutive, annual basis, hospitals receiving a Medicaid incentive payment must receive payments on a consecutive, annual basis after the year 2016. The aggregate EHR hospital incentive amount is calculated using an overall EHR amount multiplied by the Medicaid share.

Kentucky is responsible for using auditable data sources to calculate Medicaid aggregate EHR hospital incentive amounts, as well as determining Kentucky Medicaid incentive payments to those providers. Auditable data sources include:

- Providers' Medicare cost reports;
- State-specific Medicaid cost reports;
- Payment and utilization information from the Kentucky MMIS (or other automated claims processing systems or information retrieval systems); and
- Hospital financial statements and hospital accounting records.

The Kentucky Medicaid EHR Incentive Program hospital aggregate incentive amount calculation will use the equation outlined in the proposed rule, as follows:

$$\text{EH Payment} = \text{Overall EHR Amount} \times \text{Medicaid Share}$$

Where:

Overall EHR Amount = {Sum over 4 year of [(Base Amount plus Discharge Related Amount Applicable for Each Year) times Transition Factor Applicable for Each Year]}

Medicaid Share = {(Medicaid inpatient-bed-days + Medicaid managed care inpatient-bed-days) divided by [(total inpatient-bed days) times (estimated total charges minus charity care charges) divided by (estimated total charges)]}

Kentucky intends to pay the aggregate hospital incentive payment amount over a period of three annual payments, contingent on the hospital's annual attestations and registrations for the annual Kentucky Medicaid payments. The reason for this approach is that most of Kentucky's numerous rural hospitals operate on a very thin margin and need the money as soon as possible to offset their EHR system costs.

In the first year, if all conditions for payment are met, 50 percent of the aggregate amount will be paid to the EH. In the second year, if all conditions for payment are met, 40 percent of the aggregate amount will be paid to the EH. In the third year, if all conditions for payment are met, 10 percent of the aggregate amount will be paid to the EH.

Kentucky has worked with CMS on ways to effectively calculate costs. For example, charity care costs are not included on Kentucky's cost report. Kentucky has received approval from CMS to use the Kentucky Medical Assistance Program (KMAP) disproportionate share form data in lieu of cost reports for this data. A standard questionnaire is used to determine the disproportionate share.

To the extent there is simply not sufficient data that would allow us to estimate the inpatient bed-days attributable to Medicaid managed care patients, the statute directs that such figure is deemed to equal 0. Likewise, if there is simply not sufficient data for the state to estimate the percentage of inpatient bed days that are not charity care (that is, [estimated total charges—charity care charges]/estimated total charges), the statute directs that such figure is deemed to equal 1. Unlike Medicaid EPs, who must waive rights to duplicative Medicare incentive payments, hospitals may receive incentive payments from both Medicare and Medicaid, contingent on successful demonstration of meaningful use and other requirements under both programs.

The last year that a hospital may begin receiving Medicaid incentive payments is FY 2016. States must make payments over a minimum of three years. Additionally, in any given payment year, no annual Medicaid incentive payment to a hospital may exceed 50 percent of the hospital's aggregate incentive payment. Likewise, over a two-year period, no Medicaid payment to a hospital may exceed 90 percent of the aggregate incentive.

4 Registration

If this is your second year with the EHR incentive program, then there is no need to register with CMS. You may log in directly to the KYSLR to attest for Meaningful Use using the link <http://chfs.ky.gov/dms/ehr.htm>.

EHRs are required to begin by registering at the national level with the Medicare and Medicaid registration and attestation system (also referred to as the NLR). CMS' official Web site for the Medicare and Medicaid EHR Incentive Programs can be found at <http://www.cms.gov/EHRIncentivePrograms/>.

Providers must provide their name, NPI, business address, phone number, tax payer ID number (TIN) of the entity receiving the payment and hospitals must provide their CCN.

Providers must revisit the NLR to make any changes to their information and/or choices, such as changing the program from which they want to receive their incentive payment. After the

initial registration, the provider does not need to return to the NLR before seeking annual payments unless information needs to be updated. EHs seeking payment from both Medicare and Medicaid will be required to visit the NLR annually to attest to meaningful use before returning to the KYSLR system to attest for Kentucky's Medicaid EHR Incentive Program. DMS will assume meaningful use is met for hospitals deemed so for payment from the Medicare EHR Incentive Program.

The NLR will assign the provider a CMS Registration Number and electronically notify DMS of a provider's choice to access Kentucky's Medicaid EHR Incentive Program for payment. The CMS Registration Number will be needed to complete the attestation in the KYSLR system.

On receipt of NLR Registration transactions from CMS, two basic validations take place at the state level: 1) validate the NPI in the transaction is on file in the MMIS system, and 2) validate the provider is a provider with the Kentucky DMS. If either of these conditions is not met, a message will be automatically sent back to the CMS NLR indicating the provider is not eligible. Providers may check back at the NLR level to determine if the registration has been accepted.

Once payment is disbursed to the eligible TIN, NLR will be notified by DMS that a payment has been made.

5 Attestation Process & Validation

DMS will utilize the secure KYSLR system to house the attestation system. The link will only be visible to providers whose type in the MMIS system matches an EHR incentive eligible provider category. If an eligible provider registers at the NLR and does not receive the link to the attestation system within two business days, assistance will be available by contacting the DMS Provider Enrollment Call Center Operations at: (502) 564-5472.

5.1 Attestation

The following is a brief description of the information that an EH/CAH must report or attest to during the process:

1. After registering for the incentive program with the CMS EHR Registration and Attestation National Level Repository (NLR) at <http://www.cms.gov/EHRIncentivePrograms/> the EH will be asked provide:
 - Completed patient volume information on the KYSLR Web site;
 - Completed Hospital EHR Incentive Payment Worksheet;
 - Certification number for the ONC-ATCB certified EHR system (or numbers if obtained in modules).
2. The EH will be asked to attest to:
 - Adoption, implementation or upgrade of certified EHR technology or meaningful user;
 - Not receiving a Medicaid incentive payment from another state.
3. The EH will be asked to electronically sign the amendment;
 - The provider enters his/her initials and NPI on the Attestation Screen (there is a place for an agent or staff member of the provider to so identify); and

- The person filling out the form should enter his or her name.

Once the electronic attestation is submitted by a qualifying provider and appropriate documentation provided, DMS will conduct a review which will include cross-checking for potential duplication payment requests, checking provider exclusion lists and verifying supporting documentation.

The attestation itself will be electronic and will require the EH to attest to meeting all requirements defined in the federal regulations. Some documentation will have to be provided to support specific elements of attestation. All EH/CAHs will be required to submit supporting documentation for patient volume claimed in the attestation. More information on documentation will be provided in the attestation system.

During the first year of the program is the only time an EH will be allowed to attest to adopting, implementing or upgrading to certified EHR technology. It should be noted that the documentation for AIU of certified EHR technology for EHs does not have to be dated in the year of reporting. Documentation dated any time prior to the attestation is acceptable if the system and version of EHR technology has been certified by ONC (the Certified Health IT Product List can be located at ONC's website at <http://www.healthit.hhs.gov>). EHs can attest to either AIU or meaningful use as appropriate.

All EH/CAHs will be required to attest to meeting meaningful use to receive incentive payments after attesting to the Adopt, Implement, or Upgrade for the first time.

5.2 Incentive Payments

Upon completion of the attestation process, including submission of the electronic attestation, receipt of required documentation and verification by DMS, an incentive payment can be approved. Providers will be notified of approval for payment by email to the email address submitted with registration. Please be sure the email address provided is current.

5.3 Program Integrity

DMS has a contract with the Office of Inspector General (OIG) to perform audits and investigations of potential Medicaid fraud and/or abuse; therefore OIG A&I will conduct post payment incentive money audits. The audits conducted will investigate for all things attested; including, but not limited to the certified EHR technology component, percentage of Medicaid population treated, Medicaid eligibility, etc. Any documentation to which an EH attests, including meaningful use, will be audited. All reviews will ensure that no duplication of payment occurred within the commonwealth system. The OIG A&I will submit reports on audit findings and recommendations to the DMS Division of Program Integrity. All documentation supporting the attestation is to be retained for six years.

5.4 Administrative Audits/Appeals

You may appeal the determination made by the Kentucky Department for Medicaid Services on your incentive payment application. In accordance with 907 KAR 6:005 Section 13, to appeal, the EH/CAH must request a dispute resolution meeting. The request shall be in writing and mailed to and received by the department within 30 calendar days of the date the notice

was received. The request must clearly identify each specific issue and dispute, and clearly state the basis on which the department's decision on each issue is believed to be erroneous. The EH/CAH shall also state the name, mailing address, and telephone number of individuals who are expected to attend the dispute resolution meeting on the provider's behalf. Any supporting documentation to the appeal should be included with the request. The address to send the request is below:

Division of Program Integrity
 ATTN: EHR Appeal
 Department for Medicaid Services
 275 E. Main Street, 6E-A
 Frankfort, KY 40621

6 Getting Started

Hospitals will be required to provide details including patient volume characteristics, EHR details, growth rate and Medicaid. They will complete a Hospital EHR Incentive Payment worksheet as well as upload all requested documentation and electronically sign the attestation (more details follow in this manual). They will first register with the National Level Registry (NLR) at <http://www.cms.gov/EHRIncentivePrograms/>. This registration is only needed once, if this is your second year of the EHR Incentive Program then you may go directly to the KYSLR sight shown below.

The hospital provider then begins the Kentucky Medicaid EHR Incentive Program registration process by accessing the KYSLR system at <https://prdweb.chfs.ky.gov/KYSLR/Login.aspx> (sign-in screen shown below) and entering the NPI and CMS-assigned registration identifier that was received from CMS.

6.1 Sign-in

Kentucky.gov
 Cabinet for Health and Family Services
 KY Medicaid EHR Incentive Program

Release: 01.08.07.03
 KY Agencies | KY Services

User Manual | CMS EHR Site | KY Medicaid EHR Site | Send E-mail

KY Medicaid EHR Incentive Program

In order to receive EHR incentive payments from Kentucky Medicaid, you first have to register at the [CMS Web Site](#). After about 24 hours of successfully registering at the CMS level you should be able to complete your application on this site.

Please enter your NPI

Please enter the CMS assigned Registration Identifier

The EH/CAH will enter the NPI registered on the NLR and the CMS-assigned Registration Identifier that was returned by the NLR. Please allow 48 hours from registration to log into the KYSLR. The EH will only need to register once, if you are a returning provider you will be able to log in at any time.

If the data submitted by the provider matches the data received from the NLR, the Home Screen will display with the pre-populated data received from the NLR. If the provider entry does not match, an error message with instructions will be returned.

6.2 Home Screen

The Home screen provides announcements, information about the EH/CAH's current KY Attestation review as well as provides navigation to view a previous attestation or begin/modify a new attestation for the next EHR Incentive payment. This is also where the EH/CAH selects the Program year they are attesting and selects the status of their EHR; Adopt, Implement, Upgrade or Meaningful User.

KY Medicaid EHR Site Send E-mail

Home

Reports

View All Payment Years

Issues/Concerns

Appeals

Additional Resources

KY Medicaid EHR Site

CMS EHR Site

User Manuals

Provider User Manual

EP Meaningful Use Manual

EH Meaningful Use Manual

Home (Year 1 Attestation)

Announcements And Messages

No Announcements and Messages !

Issues/Concerns

Clicking the below link will redirect you to the Issues/Concerns page, where you will be able to submit any Issues and view the responses received from the DMS.

[Click Here](#)

Provider Information

You are currently enrolled in KY's EHR Incentive Program.

Payment Year '1' is your current year attestation.

The current status of your application for the year 1 payment is 'AWAITING PROVIDER ATTESTATION'.

Stage of Meaningful Use

| 1st Year | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 |
|----------|---------------------------------------|--|--------------------------------------|------|------|------|
| 2015 | MU Mod Stage 2 w/alt. avail (90 Days) | MU Mod Stage 2 w/alt. avail (365 Days) | MU Mod Stage 2 or Stage 3 (365 Days) | N/A | N/A | N/A |

Provider Status Flow

```

graph LR
    A[CMS Registration] --> B[Preliminary Verification]
    B --> C[Provider Attestation]
    A --- D[Completed]
    B --- D
    C --- E[In Process]
  
```

Provider Attestation Details

For which Program Year are you applying?

Indicate the status of your EHR:

☐ Adopt ☐ Implement ☐ Upgrade ☒ Meaningful User

[Save Attestation Details](#)

Provider Attestation Navigation

| Payment Year | Status | AttestationID | Action |
|--------------|------------------|---------------|--|
| 1 | Attest_inProcess | - | Begin/Modify Attestation |

There are seven sections to the Home page listed below:

1. **Announcements and Messages** – Displays messages or announcements for the provider.
2. **Issues/Concerns** – Provides a link for the provider to submit a new issue or view a response to an issue.
3. **Provider Information** – Provides a high-level status for the provider including the current payment year and the current status for the payment year.
4. **Stage of Meaningful Use** – Supplies the stage of Meaningful Use the provider will need to attest to according to the program year.
5. **Provider Status Flow** – Displays a diagram showing the provider's current year's attestation. If the provider has been found not eligible for any reason, specific reasons for that finding is shown in this section.
6. **Provider Attestation Details** – EH/CAH selects the Program Year and the status of their EHR. The selections available for EHR status are:
 - (A) Adopt - Acquire, purchase, or secure access to CEHRT;
 - (I) Implement - Install or commence utilization of CEHRT capable of meeting meaningful use requirements;
 - (U) Upgrade - Expand the available functionality of CEHRT capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to CEHRT per the ONC EHR certification criteria;
 - (MU) Meaningful User – currently meaningfully using CEHRT and are prepared to attest to Meaningful Use and Clinical Quality Measures.
7. **Provider Attestation Navigation** – Lists the provider's attestations by payment year and provides the navigation actions available for each year. These options may include:
 - View for a previously paid attestation;
 - View Attestation for a completed attestation;
 - Begin/Modify for a new or not yet completed attestation.

6.3 Provider Registration Data

There are two sections that make up the Provider Registration Data screen 1) Provider CMS Registration data that is pre-populated with data from the CMS Registration Module and 2) Provider Medicaid Attestation Data which contains additional fields that can be updated by the provider.

6.3.1 Provider CMS Registration Data

Registration Data (Year 1 Attestation)

Provider CMS Registration Data

*** If any of this information is incorrect, please correct on the [CMS Registration Module](#).

| | | | |
|---|---|---------------------------------|---|
| Applicant NPI: 8787878787 | Applicant TIN: 999687765 | Name: Carla's Care | Suffix: |
| Payee NPI: | Address : 275 E. Main Street , PO Box 1234 | Payee TIN: | City/State: Frankfort / KY |
| Program Option: MEDICAID | Zip Code: 40621 - 1234 | Medicaid State: KY | Phone Number: 5025640105 |
| Provider Type: Acute_Care_Hospitals | Email: Carla.Cooper@ky.gov | Participation Year: 1 | Specialty: Acute_Care_Hospitals |
| Federal Exclusions: None | State Rejection Reason: None | | |

The data displayed in the Provider CMS Registration Data section is view only. If any of this data is incorrect, the data must be updated by logging in to the CMS Registration Module, making the updates and re-submission of the registration. Please allow 24 hours for the changes to be reflected.

The fields from the CMS registration are listed below:

- **Applicant National Provider Identifier (NPI)** – The EH/CAHs registering NPI. The NPI registered at CMS should be the same NPI that is enrolled in KY Medicaid.
- **Applicant TIN** – The Tax Identification Number that was listed in the CMS registration. This TIN should be the same TIN that is listed for the provider under KY Medicaid.
- **Payee National Provider Identifier (NPI)** – The payee NPI given during the CMS registration.
- **Payee TIN** – The tax identification number associated with the payee NPI.
- **Program Option** – The program option that was selected by the provider during their registration. It will be Medicaid if you are attesting with a State Agency and not Medicare.
- **Medicaid State** – The State that was selected during the provider's registration.
- **Provider Type** – The provider type that was given during the registration at CMS.
- **Participation year** – The provider's participation year with the EHR Incentive Program
- **Federal Exclusion** – Any federal exclusions found on the provider if any during registration with CMS.
- **Name** – Then name of the EH/CAH listed on the CMS Registration
- **Address 1** – The EH/CAH's street address listed on the CMS registration
- **Address 2** – The EH/CAH's street address listed on the CMS registration
- **City/State** – The EH/CAH's city/state listed on the CMS registration
- **Zip Code** – The EH/CAH's zip code listed on the CMS registration
- **Phone Number** – The EH/CAH's phone number given on the CMS registration. This

number is used for contact by EHR staff reviewing the attestations.

- **Email** – The EH/CAH’s email given during the CMS registration. This email address is used for system-generated emails on updates for the EH/CAH’s attestation and communication from the EHR review staff. **Note:** *It is very important that this email address be accurate and up-to-date.*
- **Specialty** – The EH/CAH’s specialty listed in the CMS registration.
- **State Rejection Reason** – The state rejection reason if any are found. This will only list federal codes for rejection, for a more detailed state specific rejection see the home page.

6.3.2 Provider Medicaid Attestation Data

Provider Medicaid Attestation Data

*** Please update the data below in reference to this attestation

Mailing Address:

Address 1:
275 E. Main Street

Address 2:
PO Box 1234

City: Frankfort State: KY

ZipCode: 40621 1234

Were you assisted by a Regional Extension Center in Kentucky? ☐ Yes ☒ No

Previous Next Save Cancel

The data listed under the section **Provider Medicaid Attestation Data** is updatable by the provider during attestation. If the Provider needs their paper check mailed to an address other than the one registered with CMS in the screen above, this is where it can be changed. Once the attestation is submitted, the data will become view only. These data fields are described below:

- **Medicaid ID** - This field only displays if you have multiple Kentucky Medicaid Provider Numbers that are linked to the Payee NPI listed in your CMS registration. If so, you will need to select one of your Kentucky Medicaid Numbers. **This Medicaid Number will be used for your incentive payments.**
- **Mailing Address** - The mailing address can be updated if the provider would like to give an alternate address from the one listed from CMS for correspondence. This change will only be used for mailing the provider’s incentive payment. This will not change the address listed with CMS.
- **Medicaid Provider Type** - Please select the provider type from the list. This type should match the type of provider listed under your KY Medicaid enrollment and your type of license.
- **Were you assisted by a Regional Extension Center in Kentucky** - Response to this

question is required. If the response is yes, then please type the name of the person who assisted you during the attestation process.

6.4 Hospital Eligibility Details

EH/CAHs must enter four categories of information to complete Hospital Eligibility Details including Patient Volume, EHR Details, Growth Rate, and Medicaid Share. Hospitals will see the following data on the screen:

6.4.1 Patient Volume

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Hospital Eligibility Details (Year 1 Attestation)

(*)Red asterisk indicates a required field.

| | | |
|------------------------|---|-----------------------|
| Patient Volume: | 1. For which program year are you applying? | * 2015 |
| | What is the time frame used for patient volume calculation? | * Prior Fiscal Y |
| | 2. Select the starting date of the 90-day period(In the prior FFY) to calculate Medicaid patient volume percentage: | * 1/1/2014 (mm/dd/yy) |
| | 3.(i) Medicaid Inpatient Discharges during this period: | * 100 |
| | (ii) Medicaid ER/other Discharges (requires attestation): | * 100 |
| | (iii) Total Medicaid patient discharges during this period: | * 200 |
| | 4. Total patient discharges during this period: | * 200 |
| | 5. Medicaid patient volume percentage: | 100.00% |

1. Select the program year you wish to attest.
 - This should be either the preceding 12 months OR it can be the prior Federal Fiscal year if the current date is between 10/1/14 – 12/31/15.
2. Starting date of the consecutive 90-day period to calculate Medicaid patient volume percentage
 - This date should be a consecutive 90-day period within the Federal Fiscal Year OR the preceding 12 months prior to the program year selected above.
3. (i) Medicaid Inpatient discharges during this period
 (ii) Medicaid ER/other discharges during this period
 (iii) Total Medicaid patient discharges during this period (auto-caluculation of (i) and (ii))
4. Total patient discharges during the period
5. Medicaid patient volume percentage (auto-calculated)

6.4.2 EHR Details

| | | | |
|--------------|--|---|--|
| EHR Details: | 6. | Enter the CMS EHR Certification ID of your EHR: | * <input type="text" value="1314E01QPVP1E"/> What is this? |
| | 7. | Indicate the status of your EHR: | * <input checked="" type="radio"/> Adopt <input type="radio"/> Implement <input type="radio"/> Upgrade <input checked="" type="radio"/> Meaningful User |
| | Please select the cost report you are using? | | * <input type="text" value="Form CMS 2"/> |

6. EHR certification ID

7. Status of your EHR

- (A) Adopt - Acquire, purchase, or secure access to certified EHR technology
- (I) Implement - Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements
- (U) Upgrade - Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria
- (MU) Meaningful User - currently meaningfully using certified EHR technology and are prepared to attest to Meaningful Use and Clinical Quality Measures.

Lastly, select the cost report you are using from the drop down menu.

After attestation Year 2 and forward: Due to special circumstances does your cost report information need to be adjusted – This should only be yes if the data used to calculate your original payment included nursery or swing bed days or you have been working with the Hospital Division due to another issue and requested that you update this information.

6.4.3 Growth Rate

| | | | |
|--------------|-----|---|--|
| Growth Rate: | 8. | Select the end date of the hospital's most recently filed 12-month cost reporting period: | * <input type="text" value="12/31/2013"/> (mm/dd/yy) |
| | 9. | Total number of discharges that fiscal year: | * <input type="text" value="50"/> (w/s S-3, Part I, Col. 15, Line 14) |
| | 10. | Total number of discharges one year prior: | * <input type="text" value="100"/> |
| | 11. | Total number of discharges two years prior: | * <input type="text" value="75"/> |
| | 12. | Total number of discharges three years prior: | * <input type="text" value="50"/> |

8. End date of the hospital's most recently filed 12-month cost reporting period

9. Total number of discharges that fiscal year

- On the cost report documents this will be w/s S-3 part I, col. 15, line 14

10. Total number of discharges one year prior

11. Total number of discharges two years prior

12. Total number of discharges three years prior

6.4.4 Medicaid Share

| Medicaid Share: | |
|---|---|
| 13. Total Medicaid inpatient bed days (Exclude Nursery beds): | * <input type="text" value="75"/> (w/s S-3, Part I, Col. 7, Line 1 + Lines 8-12) |
| 14. Total Medicaid HMO inpatient bed days (Exclude Nursery beds): | * <input type="text" value="75"/> (w/s S-3, Part I, Col. 7, Line 2) |
| 15. Total inpatient bed days: | * <input type="text" value="150"/> |
| 16. Total hospital charges: | * <input type="text" value="1500.00"/> (w/s C, Part I, Col. 8, Line 200) |
| 17. (i) Inpatient Uncompensated Care Charges : | * <input type="text" value="500.00"/> (KMAP-4, Line 4) |
| (ii) Non-Inpatient Uncompensated Care Charges : | * <input type="text" value="500.00"/> (Upload signed supporting documentation) |
| (iii) Total uncompensated care charges: | * <input type="text" value="1000.00"/> |

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13. Total Medicaid inpatient bed days

- On the cost report documents this will be w/s S-3 part I, col. 7, line 14 and per CMS FAQ 10668 (FAQ 3315) should not include nursery/swing bed days

14. Total Medicaid Health Maintenance Organization (HMO) inpatient bed days

- On the cost report documents this will be w/s S-3 part I, col. 7, line

15. Total inpatient bed days

- On the cost report documents this will be w/s S-3 part I, col. 8, line

16. Total hospital charges

- On the cost report documents this will be w/s c part I, col. 8 line 202

17. (i) Inpatient uncompensated care charges

(ii) Non-Inpatient uncompensated care charges

(iii) Total uncompensated care charges (auto-calculated)

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen.
- Click **Next** to move on to the next screen.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

6.5 Meaningful Use Questionnaire

After entering the hospital eligibility details, EH/CAHs who have selected to attest for Meaningful Use will be directed to the Meaningful Use Questionnaire screen. Here, the provider will enter the Meaningful Use reporting period. For Program year 2015 the meaningful use reporting period must be a 90 day consecutive period within the current calendar year. This date should be the same date as the one attested for the Medicare Meaningful Use attestation. The SLR will locate the C5 file sent by CMS and the provider will not be requested to re-enter those measures already submitted to Medicare.

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Meaningful Use Questionnaire (Year 1 Attestation)

Meaningful Use Questionnaire

For Program year 2015, any continuous 90 days within October 1, 2014 - December 31, 2015 is permitted. Please provide the EHR reporting period associated with this attestation:

*EHR Reporting Period Start Date: (mm/dd/yy)

*EHR Reporting Period End Date: (mm/dd/yy)

*Enter the percentage of unique patients who have structured data recorded your certified EHR technology as of the reporting period above:

***Emergency Department (ED) Admissions:** An eligible hospital must choose one of the two methods to designate how patients admitted to the Emergency Department (ED) will be included in the denominators of certain Meaningful Use Core and Menu Measures. Please select the method that will be used for ALL Meaningful Use Core and Menu Measures:

☐ Observation Services Method
☒ All ED Visits Method

Enter responses for the following:

- Enter EHR Reporting Period Start Date
 - This is the starting date for the period of time you are reporting your Meaningful Use data.
- Enter EHR Reporting Period End Date
 - This is the end date for the period of time you are reporting your Meaningful Use data.
- Enter the percentage of unique patients who have structured data recorded in your certified EHR technology as of the reporting period above.
 - This is the percentage of all the patients you have seen in service location(s) with Certified EHR Technology who have data recorded in your EHR.
 - This can be calculated by dividing the number of patients with structured data in your Certified EHR by the total number of patients seen at service location(s) with Certified EHR Technology. Multiply by 100 to obtain the percentage. The amount of patients with structured data stored in your EHR should be at least 80%.
- EH/CAHs must select the method used to report how patients admitted to the emergency department will be included in the denominators of certain measures.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen.
- Click **Next** to move on to the next screen.

- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

7 Requirements for Meaningful Use Measures

Providers who are demonstrating Meaningful Use for the Kentucky Medicaid EHR program will submit and attest to the same Meaningful Use measures and Clinical Quality Measures as put forth by Medicare.

Medicaid providers who are demonstrating Meaningful Use need to meet the following requirements:

- Medicaid provider eligibility requirements;
- Medicaid volume requirements;
- For Program Year 2015, Providers must select an EHR MU reporting period that is any continuous 90-day period within the current calendar year. Providers have until May 31, 2016 to attest that EHR MU reporting period;
- 80% of unique patients must have structured data recorded in the CEHRT;
- Must meet 9 meaningful use objectives;
- Must submit 16 Clinical Quality Measures across 3 domains.

The system is designed to display the alternate objectives, exclusions and specifications accordingly for those providers who are scheduled to attest to Stage 1 and for those attesting to Modified Stage 2 requirements.

Providers will be directed through the 9 MU Objectives listed below. The Clinical Quality Measures will not be available for attestation until the MU Objectives have been completed.

- Meaningful Use Objectives
 1. Protect Patient Health Information
 2. Clinical Decision Support
 3. Computerized Provider Order Entry
 4. Electronic Prescribing
 5. Health Information Exchange
 6. Patient Specific Education
 7. Medication Reconciliation
 8. Patient Electronic Access
 9. Public Health
 - Immunization Registry Reporting
 - Syndromic Surveillance Reporting
 - Specialized Registry Reporting
 - Electronic Lab Reporting
- Clinical Quality Measures

For additional information on Meaningful Use Measures, please see the following CMS Web site below:

<https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html>

7.1 Meaningful Use Menu

The menu screen will only allow the user to select a group of measures as they are available. For example, once the Meaningful Use Core Objectives are completed, the Public Health Objectives will be active to select.

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KY Medicaid EHR Incentive Program (Year 1 Attestation)

Please select a menu option below:

- [Meaningful Use Core Objectives](#)
- [Public Health Objectives](#)
- [Clinical Quality Measures Submission](#)

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Meaningful Use Core Objectives Link - To go to the first screen of the Meaningful Use Core Objectives.

Public Health Objectives Link - To go to the first screen of the Public Health Objectives. This link is only active after the MU Core Objectives are completed.

Clinical Quality Measures Submission Link - To go to the first screen of the Clinical Quality Measures. This link is only active after the Public Health Objectives are completed.

If the user is not ready to attest, buttons at the bottom of the screen are available for navigation.

- Click **Previous** to go back to the previous screen.
- Click **Next** to move on to the next screen.

7.2 Meaningful Use Core Objectives - Scheduled for Stage 1

7.2.1 MU Core Objective 1 – Protect Patient Health Information

OBJECTIVE: Protect electronic health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities.

In order to meet this objective and measure, an EH/CAH must use the capabilities and standards as defined for CEHRT at 495.4.

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Meaningful Use Core Objectives (Year 1 Attestation)

EH Objective 1 - Protect Patient Health Information:

(*) Red asterisk indicates a required field.

Objective: Protect electronic health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities.

In order to meet this objective and measures, an EH or CAH must use the capabilities and standards as defined for CEHRT at § 495.4.

Measure: Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI created or maintained by CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the eligible hospital or CAH's risk management process.

Complete the following information:

*Have you conducted or reviewed a security risk analysis in accordance with the requirements?

☐ Yes ☐ No

Previous Next Save Cancel

In order for EH/CAHs to meet the objectives, they must be able to satisfy the measure.

To satisfy the Measure, select a response to the question.

- If No is selected, upon navigation, a message will pop up stating that the entry for the measure does not meet the threshold to qualify for an incentive payment.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

7.2.2 MU Core Objective 2 Selection – Clinical Decision Support

OBJECTIVE: Use Clinical decision support to improve performance on high-priority health conditions.

ALTERNATE OBJECTIVE: Implement one clinical decision support rule relevant to specialty or high clinical priority, or high priority hospital condition, along with the ability to track compliance with that rule.

In order to meet this objective and measures, an EH/CAH must use the capabilities and standards as defined for CEHRT at 495.4.

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EH Objective

Select the Objective you wish to attest:

☐ **Objective:** Use clinical decision support to improve performance on high-priority health conditions.

In order to meet this objective and measures, an EH or CAH must use the capabilities and standards as defined for CEHRT at § 495.4.

☐ **Alternate Objective:** Implement one clinical decision support rule relevant to specialty or high clinical priority, or high priority hospital condition, along with the ability to track compliance with that rule.

In order to meet this objective and measures, an EH or CAH must use the capabilities and standards as defined for CEHRT at § 495.4.

Measure

Complete the following information:

*Has the eligible hospital or CAH enabled and implemented the functionality for drug-drug and drug allergy interaction checks for the entire EHR reporting period?

☐ Yes ☐ No

Select the Objective being reported.

- Click **Go Back** to return to the previous screen.
- Click **Continue** to move on to the Measure details.

7.2.3 MU Core Objective 2 – Clinical Decision Support

OBJECTIVE: Use Clinical decision support to improve performance on high-priority health conditions.

In order to meet this objective and measures, an EH/CAH must use the capabilities and standards as defined for CEHRT at 495.4.

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Meaningful Use Core Objectives (Year 1 Attestation)

EH Objective 2 - Clinical Decision Support:

Objective: Use clinical decision support to improve performance on high-priority health conditions.

In order to meet this objective and measures, an EH or CAH must use the capabilities and standards as defined for CEHRT at § 495.4.

Measure 1: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an eligible hospital or CAH's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.

Complete the following information:

*Have you implemented five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period and absent four clinical quality measures related to your scope of practice or patient population, were the clinical decision support interventions related to high-priority health conditions?

☒ Yes ☐ No

If you have implemented four or more clinical quality measures related to five clinical decision support interventions, please select from the list.

| | |
|--|--|
| <input type="checkbox"/> Cervical Cancer Screening | <input type="checkbox"/> Diabetes: Eye Exam |
| <input type="checkbox"/> Colorectal Cancer Screening | <input type="checkbox"/> Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists |
| <input type="checkbox"/> Pneumonia Vaccination Status for Older Adults | <input type="checkbox"/> Preventive Care and Screening: Risk-Stratified |
| <input checked="" type="checkbox"/> Diabetes: Foot Exam | |

Measure 2: The eligible hospital or CAH has enabled and implemented the functionality for drug-drug and drug allergy interaction checks for the entire EHR reporting period.

Complete the following information:

*Has the eligible hospital or CAH enabled and implemented the functionality for drug-drug and drug allergy interaction checks for the entire EHR reporting period?

☒ Yes ☐ No

Previous Next Save Cancel

In order for EH/CAHs to meet the objective, they must satisfy both of the following measures.

To satisfy Measure 1, respond to the question.

- If Yes, select the five clinical decision support interventions implemented related to four or more clinical quality measures.
- If No, upon navigation, a pop up window will appear stating the entry for the Measure does not qualify for an incentive payment.

To satisfy Measure 2, respond to the question.

- If No is selected in response to the question for measure 2, upon navigation, a pop up window will appear stating the entry for Measure 2 does not qualify for an incentive payment.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

7.2.4 MU Core Objective 2 – Clinical Decision Support Alternate

ALTERNATE OBJECTIVE: Implement one clinical decision support rule relevant to specialty or high clinical priority, or high priority hospital condition, along with the ability to track compliance with that rule.

In order to meet this objective and measures, an EH/CAH must use the capabilities and standards as defined for CEHRT at 495.4.

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EH Objective 2 - Clinical Decision Support:

Alternate Objective: Implement one clinical decision support rule relevant to specialty or high clinical priority, or high priority hospital condition, along with the ability to track compliance with that rule.

In order to meet this objective and measures, an EH or CAH must use the capabilities and standards as defined for CEHRT at § 495.4.

Measure 1: Implement one clinical decision support rule.

Complete the following information:

*Has the EH implemented one clinical decision support rule?

☒ Yes ☐ No

*Please enter the clinical decision support rule implemented.

Measure 2: The eligible hospital or CAH has enabled and implemented the functionality for drug-drug and drug allergy interaction checks for the entire EHR reporting period.

Complete the following information:

*Has the eligible hospital or CAH enabled and implemented the functionality for drug-drug and drug allergy interaction checks for the entire EHR reporting period?

☒ Yes ☐ No

Previous **Next** **Save** **Cancel**

In order for EH/CAHs to meet the objective, they must satisfy both of the following measures.

To satisfy Measure 1, respond to the question.

- If Yes, enter the name of the clinical decision support rule implemented.

- If No, upon navigation, a message will pop up stating the entry for the Measure does not qualify for an incentive payment.

To satisfy Measure 2, respond to the question.

- If No, upon navigation, a message will pop up stating the entry for the Measure does not qualify for an incentive payment.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

7.2.5 MU Core Objective 3 Selection – Computerized Provider Order Entry

OBJECTIVE: Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional that can enter orders into the medical record per state, local, and professional guidelines.

In order to meet this objective and measures, an EH/CAH must use the capabilities and standards as defined for CEHRT at 495.4.

The screenshot displays the KY Medicaid EHR Site interface. A pop-up window titled "There are three measures applicable to this objective. Measure 1 has an alternate measure. Please select below for measure 1." is centered on the screen. The pop-up contains the following text:

Objective:
Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional that can enter orders into the medical record per state, local, and professional guidelines.

In order to meet this objective and measures, an EH or CAH must use the capabilities and standards as defined for CEHRT at § 495.4.

☐ **Measure 1:** More than 60% of medication orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.

☐ **Alternate Measure1:** More than 30% of all unique patients with at least one medication in their medication list admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have at least one medication order entered using CPOE; or more than 30% of medication orders created by the authorized providers of the eligible hospital or CAH for patients admitted to their inpatient or emergency departments (POS 21 or 23) during the EHR reporting period, are recorded using computerized provider order entry.

At the bottom of the pop-up are two buttons: "Go Back" and "Continue".

The background interface shows the KY Medicaid EHR Site navigation menu on the left, including links like Home, Reports, Meaningful Use Questionnaire, and Meaningful Use Core Objectives. The top header includes the Kentucky Department of Health logo, "Cabinet for Health and Family Services", "KY Medicaid EHR Incentive Program", and a release date of 01.58.07.00.

MEASURE 1: More than 60% of medication orders created by the authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.

ALTERNATE MEASURE 1: More than 30% of all unique patients with at least one medication in their medication list admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have at least one medication order entered using CPOE; or more than 30% of medication orders created by the authorized providers of the eligible hospital or CAH for patients admitted to their inpatient or emergency departments (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.

Select the Measure being reported to.

- Click **Continue** to move on to the Measure details.
- Click **Go Back** to return to the previous screen.

7.2.6 MU Core Objective 3 – Computerized Provider Order Entry

The screenshot shows the Kentucky.gov EHR Incentive Program portal. The header includes the Kentucky.gov logo, 'Cabinet for Health and Family Services', 'KY Medicaid EHR Incentive Program', 'Test Hospital | 3000000000', 'Logout', 'KY Agencies', 'KY Services', and 'Release: 01.58.07.00'. The left sidebar contains a navigation menu with links: Home, Reports, Meaningful Use Questionnaire, Meaningful Use Menu Options, Meaningful Use Core Objectives, Meaningful Use Public Health Objectives, Clinical Quality Measures Submission, Pre-Attestation Objective Summary, View All Payment Years, Issues/Concerns, Appeals, Additional Resources, KY Medicaid EHR Site, CMS EHR Site, User Manuals, Provider User Manual, EP Meaningful Use Manual, and EH Meaningful Use Manual. The main content area is titled 'Meaningful Use Core Objectives (Year 1 Attestation)' and features 'EH Objective 3 - Computertized Provider Order Entry:'. The objective text states: 'Objective: Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional that can enter orders into the medical record per state, local, and professional guidelines. In order to meet this objective and measures, an EH or CAH must use the capabilities and standards as defined for CEHRT at § 495.4.' Below this, 'Measure 1' is defined: 'More than 60% of medication orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.' A section for '*PATIENT RECORDS:' asks the user to select whether data was extracted from ALL patient records or only from certified EHR technology. Two radio buttons are present: the first is selected and labeled 'This data was extracted from ALL patient records not just those maintained using certified EHR technology.', and the second is labeled 'This data was extracted only from patient records maintained using certified EHR technology.' Below this, a section titled 'Complete the following information:' contains two rows: 'Numerator =' with the description 'The number of orders in the denominator recorded using CPOE.' and 'Denominator =' with the description 'Number of medication orders created by authorized providers in the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.' At the bottom, there are input fields for '*Numerator :' (containing the value 60) and '*Denominator :' (containing the value 100).

Measure 2: More than 30% of laboratory orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.

ALTERNATE EXCLUSION Providers scheduled to be in Stage 1 in 2015 may claim an exclusion for measure 2 (laboratory orders) of the Stage 2 CPOE objective for an EHR reporting period in 2015.

*Does this exclusion apply to you?

☐ Yes ☒ No

***PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

☒ This data was extracted from ALL patient records not just those maintained using certified EHR technology.

☐ This data was extracted only from patient records maintained using certified EHR technology.

Complete the following information:

Numerator = The number of orders in the denominator recorded using CPOE.

Denominator = Number of laboratory orders created by authorized providers in the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

***Numerator :** ***Denominator :**

Measure 3: More than 30% of radiology orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.

ALTERNATE EXCLUSION Providers scheduled to be in Stage 1 in 2015 may claim an exclusion for measure 3 (radiology orders) of the Stage 2 CPOE objective for an EHR reporting period in 2015.

*Does this exclusion apply to you?

☐ Yes ☒ No

***PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

☒ This data was extracted from ALL patient records not just those maintained using certified EHR technology.

☐ This data was extracted only from patient records maintained using certified EHR technology.

Complete the following information:

Numerator = The number of orders in the denominator recorded using CPOE.

Denominator = Number of radiology orders created by authorized providers in the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

***Numerator :** ***Denominator :**

[Previous](#) [Next](#) [Save](#) [Cancel](#)

An EH/CAH, through a combination of meeting the thresholds and exclusions (or both), must satisfy all three measures for this objective.

To satisfy Measure 1, make two selections.

- First, respond as to whether data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
- Second, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 60% in order to successfully attest to the measure.

To satisfy Measure 2, respond to the Alternate Exclusion.

- If No, make two selections.
 - First, respond as to whether data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
 - Second, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 30% in order to successfully attest to the measure.

To satisfy Measure 3, respond to the Alternate Exclusion.

- If No, make two selections.
 - First, respond as to whether data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
 - Second, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 30% in order to successfully attest to the measure.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

7.2.7 MU Core Objective 3 – Computerized Provider Order Entry Alternate

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 - [EP Meaningful Use Manual](#)
 - [EH Meaningful Use Manual](#)

Meaningful Use Core Objectives (Year 1 Attestation)

EH Objective 3 - Computertized Provider Order Entry:

Objective: Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional that can enter orders into the medical record per state, local, and professional guidelines.

In order to meet this objective and measures, an EH or CAH must use the capabilities and standards as defined for CEHRT at § 495.4.

Measure 1: More than 30% of all unique patients with at least one medication in their medication list admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have at least one medication order entered using CPOE; or more than 30% of medication orders created by the authorized providers of the eligible hospital or CAH for patients admitted to their inpatient or emergency departments (POS 21 or 23) during the EHR reporting period, are recorded using computerized provider order entry.

***PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

☐ This data was extracted from ALL patient records not just those maintained using certified EHR technology.
☒ This data was extracted only from patient records maintained using certified EHR technology.

Complete the following information:

Numerator = The number of orders in the denominator recorded using CPOE.

Denominator = Number of medication orders created by authorized providers in the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period

***Numerator :** ***Denominator :**

Measure 2: More than 30% of laboratory orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.

ALTERNATE EXCLUSION Providers scheduled to be in Stage 1 in 2015 may claim an exclusion for measure 2 (laboratory orders) of the Stage 2 CPOE objective for an EHR reporting period in 2015.

***Does this exclusion apply to you?**

☐ Yes ☒ No

***PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

☒ This data was extracted from ALL patient records not just those maintained using certified EHR technology.
☐ This data was extracted only from patient records maintained using certified EHR technology.

Complete the following information:

Numerator = The number of orders in the denominator recorded using CPOE.

Denominator = Number of laboratory orders created by authorized providers in the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

***Numerator :** ***Denominator :**

Measure 3: More than 30% of radiology orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.

ALTERNATE EXCLUSION Providers scheduled to be in Stage 1 in 2015 may claim an exclusion for measure 3 (radiology orders) of the Stage 2 CPOE objective for an EHR reporting period in 2015.

*Does this exclusion apply to you?

☐ Yes ☒ No

***PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

☒ This data was extracted from ALL patient records not just those maintained using certified EHR technology.

☐ This data was extracted only from patient records maintained using certified EHR technology.

Complete the following information:

Numerator = The number of orders in the denominator recorded using CPOE.

Denominator = Number of radiology orders created by authorized providers in the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

*Numerator : *Denominator :

Previous Next Save Cancel

An EH/CAH, through a combination of meeting the thresholds and exclusions (or both), must satisfy all three measures for this objective.

To satisfy Measure 1, make two selections.

- First, respond as to whether data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
- Second, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 30% in order to successfully attest to the measure.

To satisfy Measure 2, respond to the Alternate Exclusion.

- If No, make two selections.
 - First, respond as to whether data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
 - Second, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 30% in order to successfully attest to the measure.

To satisfy Measure 3, respond to the Alternate Exclusion.

- If No, make two selections.
 - First, respond as to whether data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

- Second, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 30% in order to successfully attest to the measure.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

7.2.8 MU Core Objective 4 - Electronic Prescribing

OBJECTIVE: Generate and transmit permissible prescriptions electronically (eRx).

In order to meet this objective and measure, an EH/CAH must use the capabilities and standards as defined for CEHRT at 495.4.

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EH Meaningful Use Manual

Meaningful Use Core Objectives (Year 1 Attestation)

EH Objective 4 - Electronic Prescribing:
(*) Red asterisk indicates a required field.

Objective: Generate and transmit permissible discharge prescriptions electronically (eRx).

In order to meet this objective and measure, an EH or CAH must use the capabilities and standards as defined for CEHRT at § 495.4.

Measure: More than 10% of hospital discharge medication orders for permissible prescriptions (for new and changed prescriptions) are queried for a drug formulary and transmitted electronically using CEHRT.

ALTERNATE EXCLUSION: The eligible hospital or CAH may claim an exclusion for the eRx objective and measure if for an EHR reporting period in 2015 if they were scheduled to demonstrate Stage 1, which does not have an equivalent measure.

*Does this exclusion apply to you?
☐ Yes ☒ No

***PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

☒ This data was extracted from ALL patient records not just those maintained using certified EHR technology.
☐ This data was extracted only from patient records maintained using certified EHR technology.

EXCLUSION: Any eligible hospital or CAH that does not have an internal pharmacy that can accept electronic prescriptions and is not located within 10 miles of any pharmacy that accepts electronic prescriptions at the start of their EHR reporting period.

*Does this exclusion apply to you?

☐ Yes ☒ No

Complete the following information:

Numerator = The number of prescriptions in the denominator generated, queried for a drug formulary, and transmitted electronically.

Denominator = Number of new or changed permissible prescriptions written for drugs requiring a prescription in order to be dispensed for patients discharged during the EHR reporting period.

***Numerator :**
***Denominator :**

In order for EH/CAHs to meet the objective, they must satisfy the measure by claiming the exclusion or meeting the threshold.

To satisfy the Measure, respond to the Alternate Exclusion.

- If No, make two selections.
 - First, respond as to whether data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
 - Second, respond to the Exclusion.
 - If No, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 10% in order to successfully attest to the measure.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

7.2.9 MU Core Objective 5 – Health Information Exchange

OBJECTIVE: The eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.

In order to meet this objective and measure, an EH/CAH must use the capabilities and standards as defined for CEHRT at 495.4.

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Meaningful Use Core Objectives (Year 1 Attestation)

EH Objective 5 - Health Information Exchange:

(*) Red asterisk indicates a required field.

Objective: The eligible hospital or CAH who transitions a patient to another setting of care or provider of care or refers a patient to another provider of care provides a summary care record for each transition of care or referral.

In order to meet this objective and measure, an EH or CAH must use the capabilities and standards as defined for CEHRT at § 495.4.

Measure: The eligible hospital or CAH that transitions or refers its patient to another setting of care or provider of care must do the following-- (1) use CEHRT to create a summary of care record; and (2) electronically transmit such summary to a receiving provider for more than 10% of transitions of care and referrals.

ALTERNATE EXCLUSION: Provider may claim an exclusion for the Stage 2 measure that requires the electronic transmission of a summary of care document if for an EHR reporting period in 2015, they were scheduled to demonstrate Stage 1, which does not have an equivalent measure.

*Does this exclusion apply to you?
☐ Yes ☒ No

***PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

☐ This data was extracted from ALL patient records not just those maintained using certified EHR technology.
☒ This data was extracted only from patient records maintained using certified EHR technology.

Complete the following information:

Numerator = The number of transitions of care and referrals in the denominator where a summary of care record was created using CEHRT and exchanged electronically.

Denominator = Number of transitions of care and referrals during the EHR reporting period for which the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) was the transferring or referring provider.

*Numerator : *Denominator :

Previous Next Save Cancel

In order for EH/CAHs to meet the objective, they must satisfy the measure by claiming the exclusion or meeting the threshold.

To satisfy the Measure, respond to the Alternate Exclusion.

- If No, make two selections
 - First, respond as to whether data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
 - Second, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 10% in order to successfully attest to the measure.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

7.2.10 MU Core Objective 6 – Patient Specific Education

OBJECTIVE: Use clinically relevant information from CEHRT to identify patient-specific education resources and provide those resources to the patient.

In order to meet this objective and measure, an EH/CAH must use the capabilities and standards as defined for CEHRT at 495.4.

The screenshot shows the 'Meaningful Use Core Objectives (Year 1 Attestation)' form for 'EH Objective 6 - Patient-Specific Education'. The form is part of the 'Kentucky.gov Cabinet for Health and Family Services KY Medicaid EHR Incentive Program' interface. The top navigation bar includes 'Test Hospital | 3000000000 | Logout | KY Agencies | KY Services' and a release date of '01.58.07.00'. The left sidebar contains a menu with options like 'Home', 'Reports', 'Meaningful Use Questionnaire', 'Meaningful Use Menu Options', 'Meaningful Use Core Objectives', 'Meaningful Use Public Health Objectives', 'Clinical Quality Measures Submission', 'Pre-Attestation Objective Summary', 'View All Payment Years', 'Issues/Concerns', 'Appeals', 'Additional Resources', 'KY Medicaid EHR Site', 'CMS EHR Site', 'User Manuals', 'Provider User Manual', 'EP Meaningful Use Manual', and 'EH Meaningful Use Manual'. The main content area is titled 'Meaningful Use Core Objectives (Year 1 Attestation)' and includes the following sections:

- EH Objective 6 - Patient-Specific Education**
 - (*) Red asterisk indicates a required field.
 - Objective:** Use clinically relevant information from CEHRT to identify patient-specific education resources and provide those resources to the patient.
 - In order to meet this objective and measure, an EH or CAH must use the capabilities and standards as defined for CEHRT at § 495.4.
- Measure:** More than 10% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are provided patient-specific education resources identified by CEHRT.
- ALTERNATE EXCLUSION:** Providers may claim an exclusion for the measure of the Stage 2 Patient-Specific Education objective if for an EHR reporting period in 2015 they were scheduled to demonstrate Stage 1 but did not intend to select the Stage 1 Patient Specific Education menu objective.
 - * Does this exclusion apply to you?
 - ☐ Yes
 - ☒ No
- Complete the following information:**
 - Numerator =** Number of patients in the denominator who are subsequently provided patient-specific education resources identified by CEHRT.
 - Denominator =** Number of unique patients admitted to the eligible hospital or CAH inpatient or emergency departments (POS 21 or 23) during the EHR reporting period.
 - *Numerator : *Denominator :

At the bottom of the form, there are four green buttons: 'Previous', 'Next', 'Save', and 'Cancel'.

In order for EH/CAHs to meet the objective, they must satisfy the measure by claiming the exclusion or meeting the threshold.

To satisfy the Measure, respond to the Alternate Exclusion.

- If No, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 10% in order to successfully attest to the measure.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

7.2.11 MU Core Objective 7 – Medication Reconciliation

OBJECTIVE: The eligible hospital or CAH that receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.

In order to meet this objective and measure, an EH/CAH must use the capabilities and standards as defined for CEHRT at 495.4.

The screenshot shows the 'Meaningful Use Core Objectives (Year 1 Attestation)' page on the Kentucky.gov website. The page has a blue header with the Kentucky.gov logo and navigation links. A left sidebar contains a menu with options like Home, Reports, and Meaningful Use Core Objectives. The main content area is titled 'Meaningful Use Core Objectives (Year 1 Attestation)' and contains the following sections:

- EH Objective 7 - Medication Reconciliation:** (*) Red asterisk indicates a required field.
- Objective:** The eligible hospital or CAH that receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.

In order to meet this objective and measure, an EH or CAH must use the capabilities and standards as defined for CEHRT at § 495.4.
- Measure:** The eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).
- ALTERNATE EXCLUSION:** Provider may claim an exclusion for the measure of the Stage 2 Medication Reconciliation objective if for an EHR reporting period in 2015 they were scheduled to demonstrate Stage 1 but did not intend to select the Stage 1 Medication Reconciliation menu objective.

*Does this exclusion apply to you?
☐ Yes ☒ No
- *PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

☒ This data was extracted from ALL patient records not just those maintained using certified EHR technology.
☐ This data was extracted only from patient records maintained using certified EHR technology.
- Complete the following information:**

Numerator = The number of transitions of care in the denominator where medication reconciliation was performed.

Denominator = Number of transitions of care during the EHR reporting period for which the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) was the receiving party of the transition.

*Numerator : *Denominator :

[Previous](#) [Next](#) [Save](#) [Cancel](#)

In order for EH/CAHs to meet the objective, they must satisfy the measure by claiming the exclusion or meeting the threshold.

To satisfy the Measure, respond to the Alternate Exclusion.

- If No, make two selections
 - First, respond as to whether data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
 - Second, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 50% in order to successfully attest to the measure.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

7.2.12 MU Core Objective 8 – Patient Electronic Access

OBJECTIVE: Provide patients the ability to view online, download, and transmit their health information within 36 hours of hospital discharge.

The following information must be available to satisfy the objective and measure:

- Patient name
- Admit and discharge date and location
- Reason for hospitalization
- Care team including the attending of record as well as other providers of care
- Procedures performed during admission
- Current and past problem list
- Vital signs at discharge
- Laboratory test results (available at time of discharge)
- Summary of care record for transitions of care or referrals to another provider
- Care plan field(s), including goals and instructions
- Discharge instructions for patient

- Demographics maintained by hospital (sex, race, ethnicity, date of birth, preferred language)
- Smoking status

In order to meet this objective and measures, an EH/CAH must use the capabilities and standards as defined for CEHRT at 495.4.

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Provider User Manual

EP Meaningful Use Manual

EH Meaningful Use Manual

Meaningful Use Core Objectives (Year 1 Attestation)

EP Objective 8 - Patient Electronic Access:

Both measures must be met in order for the attestation to be accepted.

Objective: Provide patients the ability to view online, download, and transmit their health information within 36 hours of hospital discharge.

The following information must be available to satisfy the objective and measure:

++ Patient name.

++ Admit and discharge date and location.

++ Reason for hospitalization.

++ Care team including the attending of record as well as other providers of care.

++ Procedures performed during admission.

++ Current and past problem list.

++ Vital signs at discharge.

++ Laboratory test results (available at time of discharge).

++ Summary of care record for transitions of care or referrals to another provider.

++ Care plan field(s), including goals and instructions.

++ Discharge instructions for patient.

++ Demographics maintained by hospital (sex, race, ethnicity, date of birth, preferred language).

++ Smoking status.

In order to meet this objective and measures, an EH or CAH must use the capabilities and standards as defined for CEHRT at § 495.4.

Measure 1: More than 50% of all unique patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH are provided timely access to view online, download and transmit to a third party their health information.

Complete the following information:

| | |
|-----------------------|--|
| Numerator = | The number of patients in the denominator who have access to view, download, and transmit their health information within 36 hours after the information is available to the eligible hospital or CAH. |
| Denominator = | Number of unique patients discharged from an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period. |
| *Numerator : | <input type="text" value="50"/> |
| *Denominator : | <input type="text" value="100"/> |

Measure 2: At least 1 patient who is discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH (or patient-authorized representative) views, downloads or transmits to a third party his or her health information during the EHR reporting period.

[The National Broadband Map \(NBM\)](#) is a searchable and interactive tool that allows users to view broadband availability across every neighborhood in the United States.

The NBM is particularly helpful for providers in the EHR Incentive Programs that need to determine their broadband download speed for exclusion criteria. Providers can use the NBM to search, analyze, and map broadband availability in their area to determine if these exclusions apply.

ALTERNATE EXCLUSION : Providers may claim an exclusion for the second measure if for an EHR reporting period in 2015 they were scheduled to demonstrate Stage 1, which does not have an equivalent measure.

***Does this exclusion apply to you?**

☐ Yes ☒ No

EXCLUSION : Any eligible hospital or CAH that is located in a county that does not have 50% or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

***Does this exclusion apply to you?**

☐ Yes ☒ No

Complete the following information:

| | |
|-----------------------|---|
| Numerator = | The number of patients (or patient-authorized representative) in the denominator who view, download, or transmit to a third party their health information. |
| Denominator = | Number of unique patients discharged from the inpatient or emergency department (POS 21 or 23) of the eligible hospital or CAH during the EHR reporting period. |
| *Numerator : | <input type="text" value="1"/> |
| *Denominator : | <input type="text" value="50"/> |

An EH/CAH, through a combination of meeting the thresholds and exclusions (or both), must satisfy both measures for this objective.

To satisfy Measure 1, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 50% in order to successfully attest to the measure.

To satisfy Measure 2, respond to the Alternate Exclusion.

- If No, respond to the Exclusion.
- If No, enter a whole number into both the Numerator and Denominator boxes. The Numerator must be greater than or equal to 1, in order to successfully attest to the measure.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.

- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

7.2.13 MU Core Objective 9 – Public Health

OBJECTIVE: The eligible hospital or CAH is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.

We further specify that providers must use the functions and standards as defined for CEHRT at 495.4 where applicable; however, as noted for measure 3 (Specialized Registry Reporting), providers may use functions beyond those established in CEHRT in accordance with state and local law.

In order to meet this objective, EHs/CAHs need to meet two of the four measures. Exclusions do not count toward meeting the objective. If the EH/CAH qualifies for multiple exclusions and the remaining number of measures available is less than two, the EH/CAH can meet the objective by meeting all remaining measures available and claiming the applicable exclusions. If no measures remain available, the EH/CAH can meet the objective by claiming applicable exclusions for all measures. An EH/CAH may report to more than one specialized registry and may count specialized registry reporting more than once to meet the required number of measures for the objective.

7.2.14 MU Core Objective 9 – Immunization Registry Reporting

MEASURE: The EH/CAH is in active engagement with a public health agency to submit immunization data.

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Pre-Attestation Objective Summary
View All Payment Years
Issues/Concerns
Appeals

Public Health Objective Measures (Year 1 Attestation)

Immunization Registry Reporting:

Objective

The eligible hospital or CAH is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.

We further specify that providers must use the functions and standards as defined for CEHRT at § 495.4 where applicable; however, as noted for measure 3 (Specialized Registry Reporting), providers may use functions beyond those established in CEHRT in accordance with state and local law.

In order to meet this objective, EHs/CAHs need to meet two of the four measures. Exclusions do not count toward meeting the objective. If the EH/CAH qualifies for multiple exclusions and the remaining number of measures available is less than two, the EH/CAH can meet the objective by meeting all remaining measures available and claiming the applicable exclusions. If no measures remain available, the EH/CAH can meet the objective by claiming applicable exclusions for all measures. An EH/CAH may report to more than one specialized registry and may count specialized registry reporting more than once to meet the required number of measures for the objective.

Additional Resources
[KY Medicaid EHR Site](#)
[CMS EHR Site](#)
User Manuals
[Provider User Manual](#)
[EP Meaningful Use Manual](#)
[EH Meaningful Use Manual](#)

Measure
The eligible hospital or CAH is in active engagement with a public health agency to submit immunization data.

***Would you like to attest to this measure?**
☒ Yes ☐ No

ALTERNATE EXCLUSION: Providers may claim an alternate exclusion for a measure if they did not intend to attest to the equivalent prior menu objective.
***Does this exclusion apply to you?**
☐ Yes ☒ No

Any eligible hospital or CAH meeting one or more of the following criteria may be excluded from the immunization registry reporting measure if the eligible hospital or CAH--

EXCLUSION 1: Does not administer any immunizations to any of the populations for which data is collected by its jurisdiction's immunization registry or immunization information system during the EHR reporting period.
***Does this exclusion apply to you?**
☐ Yes ☒ No

EXCLUSION 2: Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.
***Does this exclusion apply to you?**
☐ Yes ☒ No

EXCLUSION 3: Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data from the eligible hospital or CAH at the start of the EHR reporting period.
***Does this exclusion apply to you?**
☐ Yes ☒ No

Active Engagement Options:
Active Engagement Option 1-Completed Registration to Submit Data:The EH or CAH registered to submit data with the PHA to which the information is being submitted; registration was completed within 60 days of the beginning of the EHR reporting period; and the EH or CAH is awaiting an invitation from the PHA to begin testing and validation. This option allows providers to meet the measure when the PHA has limited resources to initiate the testing and validation process. Providers that have registered in previous years do not need to submit an additional registration to meet this requirement for each EHR reporting period.
Active Engagement Option 2 - Testing and Validation:The EH or CAH is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the PHA within 30 days; failure to respond twice within an EHR reporting period would result in that provider not meeting the measure.
Active Engagement Option 3 - Production:The EH or CAH has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA.

Please select the applicable active engagement option (may only select one).
☒ Option1
☐ Option2
☐ Option3

Previous

Next

Save

Cancel

To satisfy the Measure, respond to the question.

- If Yes, respond to the Alternate Exclusion.
- If No, respond to Exclusion 1.
- If No, respond to Exclusion 2.
- If No, respond to Exclusion 3.
 - If No, select the applicable Active Engagement Option.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

7.2.15 MU Core Objective 9 – Syndromic Surveillance Reporting

MEASURE: The EH/CAH is in active engagement with a public health agency to submit syndromic surveillance data.

The screenshot displays the 'Public Health Objective Measures (Year 1 Attestation)' page for 'Syndromic Surveillance Reporting'. The page is part of the 'KY Medicaid EHR Site' and includes a navigation menu on the left with options like Home, Reports, and Meaningful Use Questionnaire. The main content area is titled 'Public Health Objective Measures (Year 1 Attestation)' and contains the following sections:

- Syndromic Surveillance Reporting:**
 - Objective:** The eligible hospital or CAH is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice. We further specify that providers must use the functions and standards as defined for CEHRT at § 495.4 where applicable; however, as noted for measure 3 (Specialized Registry Reporting), providers may use functions beyond those established in CEHRT in accordance with state and local law. In order to meet this objective, EHS/CAHs need to meet two of the four measures. Exclusions do not count toward meeting the objective. If the EH/CAH qualifies for multiple exclusions and the remaining number of measures available is less than two, the EH/CAH can meet the objective by meeting all remaining measures available and claiming the applicable exclusions. If no measures remain available, the EH/CAH can meet the objective by claiming applicable exclusions for all measures. An EH/CAH may report to more than one specialized registry and may count specialized registry reporting more than once to meet the required number of measures for the objective.
 - Measure:** The eligible hospital or CAH is in active engagement with a public health agency to submit syndromic surveillance data.
 - *Would you like to attest to this measure?** ☒ Yes ☐ No
 - ALTERNATE EXCLUSION:** Providers may claim an alternate exclusion for a measure if they did not intend to attest to the equivalent prior menu objective.
 - *Does this exclusion apply to you?** ☐ Yes ☒ No
 - EXCLUSION 1:** Does not have an emergency or urgent care department.
 - *Does this exclusion apply to you?** ☐ Yes ☒ No

EXCLUSION 2: Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data from eligible hospitals or CAHs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.

*Does this exclusion apply to you?

☐ Yes ☒ No

EXCLUSION 3: Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from eligible hospitals or CAHs at the start of the EHR reporting period.

*Does this exclusion apply to you?

☐ Yes ☒ No

Active Engagement Options:

Active Engagement Option 1-Completed Registration to Submit Data:The EH or CAH registered to submit data with the PHA to which the information is being submitted; registration was completed within 60 days of the beginning of the EHR reporting period; and the EH or CAH is awaiting an invitation from the PHA to begin testing and validation. This option allows providers to meet the measure when the PHA has limited resources to initiate the testing and validation process. Providers that have registered in previous years do not need to submit an additional registration to meet this requirement for each EHR reporting period.

Active Engagement Option 2 - Testing and Validation:The EH or CAH is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the PHA within 30 days; failure to respond twice within an EHR reporting period would result in that provider not meeting the measure.

Active Engagement Option 3 - Production:The EH or CAH has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA.

Please select the applicable active engagement option (may only select one).

☒ Option1
☐ Option2
☐ Option3

Previous **Next** **Save** **Cancel**

To satisfy the Measure, respond to the question.


- If Yes, respond to the Alternate Exclusion.
- If No, respond to Exclusion 1.
- If No, respond to Exclusion 2.
- If No, respond to Exclusion 3.
 - If No, select the applicable Active Engagement Option.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

7.2.16 MU Core Objective 9 – Specialized Registry Reporting

MEASURE: The EH/CAH is in active engagement to submit data to a specialized registry.



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KY Medicaid EHR Incentive Program

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- Home
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- Meaningful Use Core Objectives
- Meaningful Use Public Health Objectives
- Clinical Quality Measures Submission
- Pre-Attestation Objective Summary
- View All Payment Years
- Issues/Concerns
- Appeals
- Additional Resources
 - KY Medicaid EHR Site
 - CHS EHR Site
- User Manuals
 - Provider User Manual
 - EP Meaningful Use Manual
 - EH Meaningful Use Manual

Public Health Objective Measures (Year 1 Attestation)

Specialized Registry Reporting:

Objective

The eligible hospital or CAH is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.

We further specify that providers must use the functions and standards as defined for CEHRT at § 495.4 where applicable; however, as noted for measure 3 (Specialized Registry Reporting), providers may use functions beyond those established in CEHRT in accordance with state and local law.

In order to meet this objective, EHS/CAHs need to meet two of the four measures. Exclusions do not count toward meeting the objective. If the EH/CAH qualifies for multiple exclusions and the remaining number of measures available is less than two, the EH/CAH can meet the objective by meeting all remaining measures available and claiming the applicable exclusions. If no measures remain available, the EH/CAH can meet the objective by claiming applicable exclusions for all measures. An EH/CAH may report to more than one specialized registry and may count specialized registry reporting more than once to meet the required number of measures for the objective.

Measure

The eligible hospital or CAH is in active engagement to submit data to a specialized registry.

***Would you like to attest to this measure?**

☒ Yes ☐ No

ALTERNATE EXCLUSION: Providers may claim an alternate exclusion for a measure 3 (specialized registry reporting) of the Public Health Reporting objective for an EHR reporting period in 2015, as there was no equivalent Stage 1 or Stage 2 measure.

***Does this exclusion apply to you?**

☐ Yes ☒ No

Any eligible hospital or CAH meeting at least one of the following criteria may be excluded from the specialized registry reporting measure if the eligible hospital or CAH--

EXCLUSION 1: Does not diagnose or treat any disease or condition associated with or collect relevant data that is required by a specialized registry in their jurisdiction during the EHR reporting period.

***Does this exclusion apply to you?**

☐ Yes ☒ No

EXCLUSION 2: Operates in a jurisdiction for which no specialized registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.

*Does this exclusion apply to you?

☐ Yes ☒ No

EXCLUSION 3: Operates in a jurisdiction where no specialized registry for which the eligible hospital or CAH is eligible has declared readiness to receive electronic registry transactions at the beginning of the EHR reporting period.

*Does this exclusion apply to you?

☐ Yes ☒ No

Active Engagement Options:

Active Engagement Option 1-Completed Registration to Submit Data:The EH or CAH registered to submit data with the PHA to which the information is being submitted; registration was completed within 60 days of the beginning of the EHR reporting period; and the EH or CAH is awaiting an invitation from the PHA to begin testing and validation. This option allows providers to meet the measure when the PHA has limited resources to initiate the testing and validation process. Providers that have registered in previous years do not need to submit an additional registration to meet this requirement for each EHR reporting period.

Active Engagement Option 2 - Testing and Validation:The EH or CAH is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the PHA within 30 days; failure to respond twice within an EHR reporting period would result in that provider not meeting the measure.

Active Engagement Option 3 - Production:The EH or CAH has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA.

* Please select the applicable active engagement option (may only select one).

☐ Option1
☐ Option2
☐ Option3

Instructions:

Provider may report to more than one specialized registry and may count specialized registry reporting a maximum of two times to meet the required number of measures for the objective. You may enter as many registries as you wish but only two will be counted towards the objective.

To report the first specialized registry, enter the information in the text box, then click 'Add'. To report the additional specialized registries, select the active engagement option applicable for the next registry you are reporting, enter the information in the text box and click 'Add'. Specialized Registry information you are attesting to will be displayed in the Registry table below.

* Please add the specialized registry below:

☐ Other:

LIST OF SPECIALIZED REGISTRIES YOU ADDED:

| Type of Registry | Active Engagement Option | Description | Edit | Delete |
|------------------|--------------------------|--------------------|----------------------|------------------------|
| Other | 1 | Specialty Registry | Edit | Delete |

[Add](#)

[Previous](#) [Next](#) [Save](#) [Cancel](#)

To satisfy the Measure, respond to the question.

- If Yes, respond to the Alternate Exclusion.
- If No, respond to Exclusion 1.
- If No, respond to Exclusion 2.
- If No, respond to Exclusion 3.
 - If No, make two selections
 - Select the applicable Active Engagement Option for each registry.
 - Add each specialized registry to the table.
 - When Other is selected, type the name of the registry into the text box. Click **Add** to add it to the table.

- To Edit the entries in the table, click the Edit link next to the registry to make changes. Click **Update** to accept changes or click **Cancel Edit Mode** to remove changes.
- To Delete the entries in the table, click the Delete link next to the registry.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

7.2.17 MU Core Objective 9 – Electronic Reportable Laboratory Result Reporting

MEASURE: The EH/CAH is in active engagement with a public health agency to submit electronic reportable laboratory (ELR) results.

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View All Payment Years
Issues/Concerns
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Public Health Objective Measures (Year 1 Attestation)

Electronic Reportable Laboratory Result Reporting:

Objective

The eligible hospital or CAH is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.

We further specify that providers must use the functions and standards as defined for CEHRT at § 495.4 where applicable; however, as noted for measure 3 (Specialized Registry Reporting), providers may use functions beyond those established in CEHRT in accordance with state and local law.

In order to meet this objective, EHs/CAHs need to meet two of the four measures. Exclusions do not count toward meeting the objective. If the EH/CAH qualifies for multiple exclusions and the remaining number of measures available is less than two, the EH/CAH can meet the objective by meeting all remaining measures available and claiming the applicable exclusions. If no measures remain available, the EH/CAH can meet the objective by claiming applicable exclusions for all measures. An EH/CAH may report to more than one specialized registry and may count specialized registry reporting more than once to meet the required number of measures for the objective.

Additional Resources
[KY Medicaid EHR Site](#)
[CMS EHR Site](#)
User Manuals
[Provider User Manual](#)
[EP Meaningful Use Manual](#)
[EH Meaningful Use Manual](#)

Measure
The eligible hospital or CAH is in active engagement with a public health agency to submit electronic reportable laboratory (ELR) results.

***Would you like to attest to this measure?**
☒ Yes ☐ No

ALTERNATE EXCLUSION: Providers may claim an alternate exclusion for a measure if they did not intend to attest to the equivalent prior menu objective.
***Does this exclusion apply to you?**
☐ Yes ☒ No

Any eligible hospital or CAH meeting one or more of the following criteria may be excluded from the electronic reportable laboratory result reporting measure if the eligible hospital or CAH--

EXCLUSION 1: Does not perform or order laboratory tests that are reportable in their jurisdiction during the EHR reporting period.
***Does this exclusion apply to you?**
☐ Yes ☒ No

EXCLUSION 2: Operates in a jurisdiction for which no public health agency is capable of accepting the specific ELR standards required to meet the CEHRT definition at the start of the EHR reporting period.
***Does this exclusion apply to you?**
☐ Yes ☒ No

EXCLUSION 3: Operates in a jurisdiction where no public health agency has declared readiness to receive electronic reportable laboratory results from eligible hospitals or CAHs at the start of the EHR reporting period.
***Does this exclusion apply to you?**
☐ Yes ☒ No

Active Engagement Options:
Active Engagement Option 1-Completed Registration to Submit Data:The EH or CAH registered to submit data with the PHA to which the information is being submitted; registration was completed within 60 days of the beginning of the EHR reporting period; and the EH or CAH is awaiting an invitation from the PHA to begin testing and validation. This option allows providers to meet the measure when the PHA has limited resources to initiate the testing and validation process. Providers that have registered in previous years do not need to submit an additional registration to meet this requirement for each EHR reporting period.
Active Engagement Option 2 - Testing and Validation:The EH or CAH is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the PHA within 30 days; failure to respond twice within an EHR reporting period would result in that provider not meeting the measure.
Active Engagement Option 3 - Production:The EH or CAH has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA.

Please select the applicable active engagement option (may only select one).
☐ Option1
☐ Option2
☒ Option3

Previous Next Save Cancel

To satisfy the Measure, respond to the question.

- If Yes, respond to the Alternate Exclusion.
- If No, respond to Exclusion 1.
- If No, respond to Exclusion 2.
- If No, respond to Exclusion 3.
 - If No, select the applicable Active Engagement Option.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

8 Clinical Quality Measures

8.1 Clinical Quality Measure Submission Selection Screen

The screenshot shows the 'Clinical Quality Measure (CQM) Submission Selection Screen (Year 1 Attestation)'. The header includes the Kentucky.gov logo, 'Cabinet for Health and Family Services', 'KY Medicaid EHR Incentive Program', and user details: 'Mary Contrary | 0987654321 | Logout | KY Agencies | KY Services'. The left sidebar contains links like 'Home', 'Reports', 'Meaningful Use Questionnaire', and 'Clinical Quality Measures Submission'. The main content area has a title 'Reporting Clinical Quality Measures' and instructions: 'In order to report CQMs, you will need to select the method of submission below.' A note mentions that electronic submission is encouraged for 2014 CEHRT users. Below this, there are radio buttons for 'Manually' (selected) and 'Electronically'. A section for 'Program Year 2015' requires a 90-day reporting period, with input fields for 'CQM Reporting Period Start Date' (1/1/2015) and 'CQM Reporting Period End Date' (3/31/2015). At the bottom are four buttons: 'Previous', 'Next', 'Save', and 'Cancel'.

Select how to submit CQMs, manually or electronically.

- If **Manually** is selected, enter the CQM reporting period start date and end date.
 - Start and end date must be any continuous 90-day period within the calendar year.
- If **Electronically** is selected, upon clicking **Next**, the EH/CAH is advanced to the eCQM Detail Report screen.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

8.2 Clinical Quality Measures Electronically Reported

8.2.1 eCQM Detail Report

Kentucky.gov

Cabinet for Health and Family Services
KY Medicaid EHR Incentive Program

Test User | 2111111111 | Logout

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KY Agencies | KY Services

KY Medicaid EHR Site

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Meaningful Use Questionnaire

Meaningful Use Menu Options

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Meaningful Use Public Health Objectives

Clinical Quality Measures Submission

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Additional Resources

KY Medicaid EHR Site

CMS EHR Site

User Manuals

Provider User Manual

EP Meaningful Use Manual

EH Meaningful Use Manual

eCQM (Year 2 Attestation)

eCQM Detail Report

QRDA File Upload

Please use the browse function below to upload your eCQM file following HL7 Standards (<http://www.hl7.org/>). QRDA III xml files are required and you must meet CMS defined thresholds in order to successfully attest. The most recent submission with an accepted status will be used for validation. QRDA I xml files will be accepted however will not fulfill the requirement of electronic submission of eCQMs.

Uploaded Invalid Files

No errors to report.

To view the eMeasures from your QRDA III file, click the select link in the corresponding row. Before proceeding, please review the eMeasures and details.

The most recent submission with an accepted status will be used for validation.

Rows that do not include a select link are QRDA I documents that have been uploaded.

Uploaded Valid Files

| | FileTransmissionID | Status | DateReceived | FileName |
|------------------------|--------------------|----------|----------------------|--|
| Select | 538 | Accepted | 2/23/2016 9:42:03 AM | 2015 KLIPPENSTEIN KELLI - NPI 2111111111.xml |

Selected File ECQMs

| Measure Details | | | | | Domain |
|--|--------------------------------------|-------------------------|--------------------|--------------------------------------|----------------------------------|
| eMeasure Title | Version Neutral ID | eMeasure Version Number | NQF Measure Number | Version Specific ID | |
| Use of High-Risk Medications in the Elderly | a3837ff8-1abc-4ba9-800e-fd4e7953adbd | 2 | | 40280381-3D61-56A7-013E-65C9C3043E54 | Patient Safety |
| <p>Member of Measure Set: NONE - eMeasure ID:5b3d9245-fb54-499c-b5c5-21c20564f0bd</p> <p>Initial Patient Population: 73 SexFemale: 48Male: 23Undifferentiated; 2 EthnicityHispanic or Latino: 7Not Hispanic or Latino: 5 PayerMEDICARE: 2BLUE CROSS/BLUE SHIELD: 1Unavailable / Unknown: 70 RaceAsian: 5Black or African American: 3White: 4Other Race: 2 Denominator: 73 SexFemale: 48Male: 23Undifferentiated; 2 EthnicityHispanic or Latino: 7Not Hispanic or Latino: 5 PayerMEDICARE: 2BLUE CROSS/BLUE SHIELD: 1Unavailable / Unknown: 70 RaceAsian: 5Black or African American: 3White: 4Other Race: 2 Numerator 1: 22 SexFemale: 14Male: 8 PayerUnavailable / Unknown: 22 Numerator 2: 10 SexFemale: 5Male: 5 PayerUnavailable / Unknown: 10</p> | | | | | |
| CERVICAL CANCER SCREENING | 42e7e489-790f-427a-a1a6-d6e807f65a6d | 2 | | 40280381-3D61-56A7-013E-669CBC034836 | Clinical Process / Effectiveness |
| <p>Member of Measure Set: NONE - eMeasure ID:e1d695b0-acee-472f-bfaf-ddb6e1515933</p> <p>Initial Patient Population: 107 SexFemale: 107 EthnicityNot Hispanic or Latino: 3 PayerMEDICARE: 20BLUE CROSS/BLUE SHIELD: 1Unavailable / Unknown: 86 RaceAmerican Indian or Alaska Native: 1Black or African American: 2 Denominator: 107 SexFemale: 107 EthnicityNot Hispanic or Latino: 3 PayerMEDICARE: 20BLUE CROSS/BLUE SHIELD: 1Unavailable / Unknown: 86 RaceAmerican Indian or Alaska Native: 1Black or African American: 2Numerator: 0Denominator Exclusions: 0</p> | | | | | |

| | <table><tr><th>eMeasure Title</th><th>Version Neutral ID</th><th>eMeasure Version Number</th><th>NQF Measure Number</th><th>Version Specific ID</th></tr><tr><td>Chlamydia Screening in Women</td><td>c9930664-be3d-4ffe-ae4a-5cf4933ecb89</td><td>2</td><td></td><td>40280381-3D61-56A7-013E-5D4001866C09</td></tr></table> <p>Member of Measure Set: NONE - eMeasure ID:60caa8bf-3285-4d63-b686-0d737eec5e53 Initial Patient Population: 0 StrataReporting Stratum 1: 0Reporting Stratum 2: 0 Denominator: 0 StrataReporting Stratum 1: 0Reporting Stratum 2: 0 Numerator: 0 StrataReporting Stratum 1: 0Reporting Stratum 2: 0 Denominator Exclusions: 0 StrataReporting Stratum 1: 0Reporting Stratum 2: 0</p> | eMeasure Title | Version Neutral ID | eMeasure Version Number | NQF Measure Number | Version Specific ID | Chlamydia Screening in Women | c9930664-be3d-4ffe-ae4a-5cf4933ecb89 | 2 | | 40280381-3D61-56A7-013E-5D4001866C09 | Population and Public Health |
|---|---|-------------------------|--------------------|--------------------------------------|--------------------|---------------------|---|--------------------------------------|---|--|--------------------------------------|----------------------------------|
| eMeasure Title | Version Neutral ID | eMeasure Version Number | NQF Measure Number | Version Specific ID | | | | | | | | |
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| | <table><tr><th>eMeasure Title</th><th>Version Neutral ID</th><th>eMeasure Version Number</th><th>NQF Measure Number</th><th>Version Specific ID</th></tr><tr><td>Preventive Care and Screening: Influenza Immunization</td><td>a244aa29-7d11-4616-888a-86e376bfcc6f</td><td>2</td><td></td><td>40280381-3D61-56A7-013E-57F49972361A</td></tr></table> <p>Member of Measure Set: NONE - eMeasure ID:40d83c98-aaa9-4436-9c12-54b0896b0b2c Initial Patient Population: 158 SexFemale: 51Male: 104Undifferentiated: 3 EthnicityHispanic or Latino: 6Not Hispanic or Latino: 4 PayerMEDICARE: 6Unavailable / Unknown: 152 RaceAmerican Indian or Alaska Native: 3Asian: 4White: 10Other Race: 2 Denominator: 83 SexFemale: 17Male: 66 EthnicityHispanic or Latino: 1Not Hispanic or Latino: 1 PayerMEDICARE: 1Unavailable / Unknown: 82 RaceAmerican Indian or Alaska Native: 1Asian: 1 Numerator: 15 SexFemale: 3Male: 12 PayerUnavailable / Unknown: 15 Denominator Exceptions: 24 SexFemale: 6Male: 18 PayerUnavailable / Unknown: 24</p> | eMeasure Title | Version Neutral ID | eMeasure Version Number | NQF Measure Number | Version Specific ID | Preventive Care and Screening: Influenza Immunization | a244aa29-7d11-4616-888a-86e376bfcc6f | 2 | | 40280381-3D61-56A7-013E-57F49972361A | Population and Public Health |
| eMeasure Title | Version Neutral ID | eMeasure Version Number | NQF Measure Number | Version Specific ID | | | | | | | | |
| Preventive Care and Screening: Influenza Immunization | a244aa29-7d11-4616-888a-86e376bfcc6f | 2 | | 40280381-3D61-56A7-013E-57F49972361A | | | | | | | | |
| | <table><tr><th>eMeasure Title</th><th>Version Neutral ID</th><th>eMeasure Version Number</th><th>NQF Measure Number</th><th>Version Specific ID</th></tr><tr><td>Pneumonia Vaccination Status for Older Adults</td><td>59657b9b-01bf-4979-a090-8534da1d0516</td><td>2</td><td></td><td>40280381-3D61-56A7-013E-66A79D4A4A23</td></tr></table> <p>Member of Measure Set: NONE - eMeasure ID:097e91e6-bb8d-4f16-9acf-f7d9dce26799 Initial Patient Population: 75 SexFemale: 49Male: 24Undifferentiated: 2 EthnicityHispanic or Latino: 7Not Hispanic or Latino: 6 PayerMEDICARE: 2BLUE CROSS/BLUE SHIELD: 1Unavailable / Unknown: 72 RaceAsian: 5Black or African American: 3White: 5Other Race: 2 Denominator: 75 SexFemale: 49Male: 24Undifferentiated: 2 EthnicityHispanic or Latino: 7Not Hispanic or Latino: 6 PayerMEDICARE: 2BLUE CROSS/BLUE SHIELD: 1Unavailable / Unknown: 72 RaceAsian: 5Black or African American: 3White: 5Other Race: 2 Numerator: 1 SexFemale: 1 PayerUnavailable / Unknown: 1</p> | eMeasure Title | Version Neutral ID | eMeasure Version Number | NQF Measure Number | Version Specific ID | Pneumonia Vaccination Status for Older Adults | 59657b9b-01bf-4979-a090-8534da1d0516 | 2 | | 40280381-3D61-56A7-013E-66A79D4A4A23 | Clinical Process / Effectiveness |
| eMeasure Title | Version Neutral ID | eMeasure Version Number | NQF Measure Number | Version Specific ID | | | | | | | | |
| Pneumonia Vaccination Status for Older Adults | 59657b9b-01bf-4979-a090-8534da1d0516 | 2 | | 40280381-3D61-56A7-013E-66A79D4A4A23 | | | | | | | | |
| | <table><tr><th>eMeasure Title</th><th>Version Neutral ID</th><th>eMeasure Version Number</th><th>NQF Measure Number</th><th>Version Specific ID</th></tr><tr><td>Diabetes: Foot Exam</td><td>c0d72444-7c26-4863-9b51-8080f8928a85</td><td>2</td><td></td><td>40280381-3D61-56A7-013E-5D11ABE068EB</td></tr></table> <p>Member of Measure Set: NONE - eMeasure ID:e5a14575-bfe4-473a-beae-32d13922bb52 Initial Patient Population: 111 SexFemale: 65Male: 44Undifferentiated: 2 EthnicityHispanic or Latino: 2Not Hispanic or Latino: 5 PayerMEDICARE: 2BLUE CROSS/BLUE SHIELD: 1Unavailable / Unknown: 108 RaceAmerican Indian or Alaska Native: 1Black or African American: 2White: 20Other Race: 2 Denominator: 96 SexFemale: 60Male: 34Undifferentiated: 2 EthnicityHispanic or Latino: 2Not Hispanic or Latino: 5 PayerMEDICARE: 2BLUE CROSS/BLUE SHIELD: 1Unavailable / Unknown: 93 RaceAmerican Indian or Alaska Native: 1Black or African American: 2White: 20Other Race: 2 Numerator: 14 SexFemale: 2Male: 12 EthnicityNot Hispanic or Latino: 1 PayerMEDICARE: 1Unavailable / Unknown: 13 RaceAmerican Indian or Alaska Native: 1 Denominator Exclusions: 15 SexFemale: 5Male: 10 PayerUnavailable / Unknown: 15</p> | eMeasure Title | Version Neutral ID | eMeasure Version Number | NQF Measure Number | Version Specific ID | Diabetes: Foot Exam | c0d72444-7c26-4863-9b51-8080f8928a85 | 2 | | 40280381-3D61-56A7-013E-5D11ABE068EB | Clinical Process / Effectiveness |
| eMeasure Title | Version Neutral ID | eMeasure Version Number | NQF Measure Number | Version Specific ID | | | | | | | | |
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| | <table><tr><th>eMeasure Title</th><th>Version Neutral ID</th><th>eMeasure Version Number</th><th>NQF Measure Number</th><th>Version Specific ID</th></tr><tr><td>Diabetes: HbA1c Poor Control</td><td>f2986519-5a4e-4149-a8f2-af0a1dc7f6bc</td><td>2</td><td></td><td>40280381-3D61-56A7-013E-62240559256D</td></tr></table> | eMeasure Title | Version Neutral ID | eMeasure Version Number | NQF Measure Number | Version Specific ID | Diabetes: HbA1c Poor Control | f2986519-5a4e-4149-a8f2-af0a1dc7f6bc | 2 | | 40280381-3D61-56A7-013E-62240559256D | Clinical Process / Effectiveness |
| eMeasure Title | Version Neutral ID | eMeasure Version Number | NQF Measure Number | Version Specific ID | | | | | | | | |
| Diabetes: HbA1c Poor Control | f2986519-5a4e-4149-a8f2-af0a1dc7f6bc | 2 | | 40280381-3D61-56A7-013E-62240559256D | | | | | | | | |

| | | <p>Member of Measure Set: NONE - eMeasure ID:bc0c7003-0d58-4dbd-a135-fe4456de3432 Initial Patient Population: 111 SexFemale: 65Male: 44Undifferentiated: 2 EthnicityHispanic or Latino: 2Not Hispanic or Latino: 5 PayerMEDICARE: 2BLUE CROSS/BLUE SHIELD: 1Unavailable / Unknown: 108 RaceAmerican Indian or Alaska Native: 1Black or African American: 2White: 2Other Race: 2 Denominator: 108 SexFemale: 62Male: 44Undifferentiated: 2 EthnicityHispanic or Latino: 2Not Hispanic or Latino: 5 PayerMEDICARE: 2BLUE CROSS/BLUE SHIELD: 1Unavailable / Unknown: 105 RaceAmerican Indian or Alaska Native: 1Black or African American: 2White: 2Other Race: 2 Numerator: 108 SexFemale: 62Male: 44Undifferentiated: 2 EthnicityHispanic or Latino: 2Not Hispanic or Latino: 5 PayerMEDICARE: 2BLUE CROSS/BLUE SHIELD: 1Unavailable / Unknown: 105 RaceAmerican Indian or Alaska Native: 1Black or African American: 2White: 2Other Race: 2 Denominator Exclusions: 3 SexFemale: 3 PayerUnavailable / Unknown: 3</p> <table border="1"> <thead> <tr> <th>eMeasure Title</th><th>Version Neutral ID</th><th>eMeasure Version Number</th><th>NQF Measure Number</th><th>Version Specific ID</th></tr> </thead> <tbody> <tr> <td>Diabetes: Urine Protein Screening</td><td>7b2a9277-43da-4d99-9bee-6ac271a07747</td><td>2</td><td></td><td>40280381-3D61-56A7-013E-62ABF5662FFF</td></tr> </tbody> </table> <p>Member of Measure Set: NONE - eMeasure ID:6122e70a-c683-4c01-a521-c72afbd564f9 Initial Patient Population: 111 SexFemale: 65Male: 44Undifferentiated: 2 EthnicityHispanic or Latino: 2Not Hispanic or Latino: 5 PayerMEDICARE: 2BLUE CROSS/BLUE SHIELD: 1Unavailable / Unknown: 108 RaceAmerican Indian or Alaska Native: 1Black or African American: 2White: 2Other Race: 2 Denominator: 106 SexFemale: 62Male: 42Undifferentiated: 2 EthnicityHispanic or Latino: 2Not Hispanic or Latino: 5 PayerMEDICARE: 2BLUE CROSS/BLUE SHIELD: 1Unavailable / Unknown: 103 RaceAmerican Indian or Alaska Native: 1Black or African American: 2White: 2Other Race: 2 Numerator: 30 SexFemale: 30 EthnicityNot Hispanic or Latino: 1 PayerMEDICARE: 1Unavailable / Unknown: 29 RaceAmerican Indian or Alaska Native: 1 Denominator Exclusions: 5 SexFemale: 3Male: 2 PayerUnavailable / Unknown: 5</p> | eMeasure Title | Version Neutral ID | eMeasure Version Number | NQF Measure Number | Version Specific ID | Diabetes: Urine Protein Screening | 7b2a9277-43da-4d99-9bee-6ac271a07747 | 2 | | 40280381-3D61-56A7-013E-62ABF5662FFF | Clinical Process / Effectiveness | | | | | | | | | | | | | | | | | | | | | |
|---|--------------------------------------|--|------------------------------|--------------------------------------|-------------------------|--------------------|---------------------|--------------------------------------|--------------------------------------|---|--|--------------------------------------|----------------------------------|--------------------|-------------------------|--------------------|---------------------|---|--------------------------------------|---|--|--------------------------------------|----------------|--------------------|-------------------------|--------------------|---------------------|--|--|--|--|--|----------------------------------|--|
| eMeasure Title | Version Neutral ID | eMeasure Version Number | NQF Measure Number | Version Specific ID | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Diabetes: Urine Protein Screening | 7b2a9277-43da-4d99-9bee-6ac271a07747 | 2 | | 40280381-3D61-56A7-013E-62ABF5662FFF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| eMeasure Title | Version Neutral ID | eMeasure Version Number | NQF Measure Number | Version Specific ID | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Diabetes: LDL Management And Control | 0dac1dec-e011-493b-a281-7c28964872dd | 2 | | 40280381-3D61-56A7-013E-5D5B19BF6DFB | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| eMeasure Title | Version Neutral ID | eMeasure Version Number | NQF Measure Number | Version Specific ID | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ischemic Vascular Disease (IVD); Use of Aspirin or Another Antithrombotic | 0713ea8f-0e5b-4099-8c7c-dd677280398f | 2 | | 40280381-3D61-56A7-013E-7BC5AEC17282 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| eMeasure Title | Version Neutral ID | eMeasure Version Number | NQF Measure Number | Version Specific ID | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Population and Public Health | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

There are four sections to consider on the eCQM Detail Report including QRDA File Upload, Uploaded Invalid Files, Uploaded Valid Files, and Selected File eCQMs.

- To upload the eCQM file, click **Browse** to locate the extracted QRDA III file. Click the **Upload QRDA File** button to upload.

- Note that to upload the eCQM file follow the HL7 Standards (<http://www.hl7.org/>). QRDA III xml files are required and you must meet CMS defined thresholds in order to successfully attest. QRDA I xml files will be accepted however will not fulfill the requirement of electronic submission of eCQMs.

Uploaded Invalid Files

- The file is listed in this section if there are errors found in the report.

Uploaded Valid Files

- If file upload is successful, the file will appear here. Click the **Select** link to display the details of the eCQMs.
 - The most recent submission with an accepted status will be used for validation. Rows that do not include a Select link are QRDA I documents that have been uploaded.

Selected Files

- This section will display all of the measure details from the file selected.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Continue** to move on to the eCQM Summary Report.

8.2.2 eCQM Summary Report

Kentucky.gov
Cabinet for Health and Family Services
KY Medicaid EHR Incentive Program

Release: 01.58.07.03
Test User | 2111111111 | Logout | KY Agencies | KY Services

KY Medicaid EHR Site | Send E-mail

Home
Reports
Meaningful Use Questionnaire
Meaningful Use Menu Options
Meaningful Use Core Objectives
Meaningful Use Public Health Objectives
Clinical Quality Measures Submission
Pre-Attestation Objective Summary
View All Payment Years
Issues/Concerns
Appeals
Additional Resources
KY Medicaid EHR Site
CMS EHR Site
User Manuals
Provider User Manual
EP Meaningful Use Manual
EH Meaningful Use Manual

eCQM (Year 2 Attestation)

eCQM Summary Report

| | | | |
|--|---------------------------------|---|---|
| Date Received 2/23/2016 9:42:03 AM | Report NPI 2111111111 | Reporting Period Start 1/1/2015 12:00:00 AM | Reporting Period End 3/31/2015 12:00:00 AM |
| Document Type QRDA III | eCQM Status: Accepted | Evaluated Date: 2/23/2016 9:43:03 AM | File Name: 2015 KLIPPENSTEIN KELLI - NPI 2111111111.xml |

| Domain | Has Data Entry | # Measures Entered |
|---------------------------------------|----------------|--------------------|
| Patient and Family Engagement | 0 | 0 |
| Patient Safety | 1 | 1 |
| Care Coordination | 0 | 0 |
| Population and Public Health | 1 | 4 |
| Efficient Use of Healthcare Resources | 0 | 0 |
| Clinical Process/Effectiveness | 1 | 9 |

Total Met 3 14

Total Required 3 of 6 9 of 64

Final eCQM Result: Submission Accepted, click Next to continue.

Previous

Evaluate eCQM Submissions

Next

Review the eCQM Summary Report. Click **Evaluate eCQM Submissions** to display the Final eCQM Result of the submission being accepted or rejected.

After review of the eCQM final report, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.

8.3 Clinical Quality Measures Manually Reported

8.3.1 Clinical Quality Measure CMS55

KY Medicaid EHR Site Send E-mail

Home
Reports
Meaningful Use Questionnaire
Meaningful Use Menu Options
Meaningful Use Core Objectives
Meaningful Use Public Health Objectives
Clinical Quality Measures Submission
Pre-Attestation Objective Summary
View All Payment Years
Issues/Concerns
Appeals
Additional Resources
KY Medicaid EHR Site
CMS EHR Site
User Manuals
Provider User Manual
EP Meaningful Use Manual
EH Meaningful Use Manual

Carla's Care | 8787878787 | Logout | KY Agencies | KY Services

Release: 01.58.07.03

Clinical Quality Measures (Year 1 Attestation)

Questionnaire 1 of 16
(*) Red asterisk indicates a required field.

Measure: CMS55/NQF 0495
Versions: CMS55v3
Title: Median Time from ED Arrival to ED Departure for Admitted ED Patients
Description: Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department.

Denominator : N/A
Numerator : N/A
Denominator Exclusions: N/A
Denominator Exceptions : N/A

Complete the following information:

Stratum 1 - all patients seen in the ED and admitted as an inpatient.

* Average % of Time:
5.00

Stratum 2 - all patients seen in the ED and admitted as an inpatient who do not have a diagnosis consistent with psychiatric/mental health disorders.

* Average % of Time:
10.00

Stratum 3 - all patients seen in the ED and admitted as an inpatient who have a diagnosis consistent with psychiatric/mental health disorders.

* Average % of Time:
15.00

Previous Next Save Cancel

To satisfy this CQM, enter the average % of time for all three Stratum.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

8.3.2 Clinical Quality Measure CMS71

Kentucky.gov
Cabinet for Health and Family Services
KY Medicaid EHR Incentive Program

Release: 01.58.07.03
Carla's Care | 8787878787 | Logout | KY Agencies | KY Services

KY Medicaid EHR Site | Send E-mail

Home
Reports
Meaningful Use Questionnaire
Meaningful Use Menu Options
Meaningful Use Core Objectives
Meaningful Use Public Health Objectives
Clinical Quality Measures Submission
Pre-Attestation Objective Summary
View All Payment Years
Issues/Concerns
Appeals
Additional Resources
KY Medicaid EHR Site
CMS EHR Site
User Manuals
Provider User Manual
EP Meaningful Use Manual
EH Meaningful Use Manual

Clinical Quality Measures (Year 1 Attestation)

Questionnaire 2 of 16
(*) Red asterisk indicates a required field.

Measure: CMS71/NQF 0436
Versions: CMS71v4
Title: Anticoagulation Therapy for Atrial Fibrillation/Flutter
Description: Ischemic stroke patients with atrial fibrillation/flutter who are prescribed anticoagulation therapy at hospital discharge.

Denominator: Patients with a principal diagnosis of ischemic stroke and current or history of atrial fibrillation/flutter.
Numerator: Patients prescribed anticoagulation therapy at hospital discharge.

Denominator Exclusions:
Exclusion 1: Patients with comfort measures documented. Patients admitted for elective carotid intervention. This exclusion is implicitly modeled by only including non-elective hospitalizations.
Patients discharged to another hospital.
Patients who left against medical advice.
Patients who expired.
Patients discharged to home for hospice care.
Patients discharged to a health care facility for hospice care.

Denominator Exceptions:
Exception 1: Patients with a documented reason for not prescribing anticoagulation therapy.

Complete the following information:

* Denominator 1: * Numerator 1: * Performance Rate 1 (%): * Exclusion 1:
* Exception 1:

Previous Next Save Cancel

To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, Exclusion, and Exception boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

8.3.3 Clinical Quality Measure CQM72

Kentucky.gov
Cabinet for Health and Family Services
KY Medicaid EHR Incentive Program

Release: 01.58.07.03
Carla's Care | 8787878787 | Logout | KY Agencies | KY Services

KY Medicaid EHR Site | Send E-mail

Home
Reports
Meaningful Use Questionnaire
Meaningful Use Menu Options
Meaningful Use Core Objectives
Meaningful Use Public Health Objectives
Clinical Quality Measures Submission
Pre-Attestation Objective Summary
View All Payment Years
Issues/Concerns
Appeals
Additional Resources
KY Medicaid EHR Site
CMS EHR Site
User Manuals
Provider User Manual
EP Meaningful Use Manual
EH Meaningful Use Manual

Clinical Quality Measures (Year 1 Attestation)

Questionnaire 3 of 16
(*) Red asterisk indicates a required field.

Measure: CMS72/NQF 0438
Versions: CMS72v3

Title: Antithrombotic Therapy by End of Hospital Day 2
Description: Ischemic stroke patients administered antithrombotic therapy by the end of hospital day 2.

Denominator: Patients with a principal diagnosis of Ischemic stroke.
Numerator: Patients who had antithrombotic therapy administered the day of or day after hospital arrival.

Denominator Exclusions: Exclusion 1: Patients who have a duration of stay less than 2 days. Patients with comfort measures documented on day or the day after arrival. Patients with intra-venous or intra-arterial Thrombolytic (t-PA) Therapy administered within 24 hours prior to arrival or anytime during hospitalization.

Denominator Exceptions: Exception 1: Patients with a documented reason for not administering antithrombotic therapy the day of or day after hospital arrival.

Complete the following information:

* Denominator 1: 1 * Numerator 1: 1 * Performance Rate 1 (%): 1.00 * Exclusion 1: 1
* Exception 1: 1

Previous Next Save Cancel

To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, Exclusion, and Exception boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

8.3.4 Clinical Quality Measure CQM73

Kentucky.gov
Cabinet for Health and Family Services
KY Medicaid EHR Incentive Program

Release: 01.58.07.03
Carla's Care | 8787878787 | Logout | KY Agencies | KY Services

KY Medicaid EHR Site | Send E-mail

Clinical Quality Measures (Year 1 Attestation)

Questionnaire 4 of 16
(*) Red asterisk indicates a required field.

Measure: CMS73/NQF 0373
Versions: CMS73v3

Title: Venous Thromboembolism Patients with Anticoagulation Overlap Therapy

Description: This measure assesses the number of patients diagnosed with confirmed VTE who received an overlap of parenteral (intravenous [IV] or subcutaneous [subcu]) anticoagulation and warfarin therapy. For patients who received less than five days of overlap therapy, they should be discharged on both medications or have a reason for discontinuation of overlap therapy. Overlap therapy should be administered for at least five days with an international normalized ratio (INR) greater than or equal to 2 prior to discontinuation of the parenteral anticoagulation therapy, discharged on both medications or have a reason for discontinuation of overlap therapy.

Denominator: Patients with confirmed VTE who received warfarin.

Numerator: Patients who received overlap therapy (warfarin and parenteral anticoagulation):
Five or more days, with an INR greater than or equal to 2 prior to discontinuation of parenteral therapy OR
Five or more days, with an INR less than 2 and discharged on overlap therapy OR
Less than five days and discharged on overlap therapy OR
With documentation of reason for discontinuation of parenteral therapy OR
With documentation of a reason for no overlap therapy.

Denominator Exclusions: Exclusion 1: Patients with Comfort Measures documented.
Patients discharged to a health care facility for hospice care.
Patients discharged to home for hospice care.
Patients who expired.
Patients who left against medical advice.
Patients discharged to another hospital.
Patients without warfarin therapy during hospitalization.
Patients without VTE confirmed by diagnostic testing.

Complete the following information:

| * Denominator 1: | * Numerator 1: | * Performance Rate 1 (%): | * Exclusion 1: |
|------------------|----------------|---------------------------|----------------|
| 1 | 1 | 1.00 | 1 |

Previous **Next** **Save** **Cancel**

To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

8.3.5 Clinical Quality Measure CQM91

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Clinical Quality Measures (Year 1 Attestation)

Questionnaire 5 of 16
(*) Red asterisk indicates a required field.

Measure: CMS91/NQF 0437
Versions: CMS91v4
Title: Thrombolytic Therapy
Description: Acute ischemic stroke patients who arrive at this hospital within 2 hours of time last known well and for whom IV t-PA was initiated at this hospital within 3 hours of time last known well.

Denominator: Ischemic stroke patients admitted through the Emergency Department whose time of arrival is within 2 hours (less than or equal to 120 minutes) of 1) time they were known to be at their baseline state of health; or 2) time of symptom onset if time last known at baseline state is not known.

Numerator: Acute Ischemic stroke patients for whom IV thrombolytic therapy was initiated at this hospital within 3 hours (less than or equal to 180 minutes) of when it was witnessed or reported that the patient was last known to be without the signs and symptoms of the current stroke or at his or her baseline state of health.

Denominator Exceptions: Exception 1: Patients with a documented Reason For Not Initiating IV Thrombolytic.

Complete the following information:

* Denominator 1: 1 * Numerator 1: 1 * Performance Rate 1 (%): 1.00 * Exception 1: 1

Previous Next Save Cancel

To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exception boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

8.3.6 Clinical Quality Measure CQM102

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Clinical Quality Measures (Year 1 Attestation)

Questionnaire 6 of 16
(*) Red asterisk indicates a required field.

Measure: CMS102/NQF 0441
Versions: CMS102V3
Title: Assessed for Rehabilitation
Description: Ischemic or hemorrhagic stroke patients who were assessed for rehabilitation services.

Denominator: Patients age 18 and older discharged from inpatient care (non-elective admissions) with a principal diagnosis of ischemic or hemorrhagic stroke and a length of stay less or equal to 120 days.
Numerator: Patients assessed for or who received rehabilitation services.

Denominator Exclusions:
Exclusion 1: Patients with comfort measures documented.
Patients discharged to another hospital.
Patients who left against medical advice.
Patients who expired.
Patients discharged to home for hospice care.
Patients discharged to a health care facility for hospice care.

Complete the following information:

* Denominator 1: 1 * Numerator 1: 1 * Performance Rate 1 (%): 1.00 * Exclusion 1: 1

Previous Next Save Cancel

To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

8.3.7 Clinical Quality Measure CQM104

The screenshot shows the 'Clinical Quality Measures (Year 1 Attestation)' page for CQM104. The page is titled 'Questionnaire 7 of 16' and includes a note: '(*) Red asterisk indicates a required field.' The main content area displays the following information:

- Measure:** CMS104/NQF 0435
- Versions:** CMS104v3
- Title:** Discharged on Antithrombotic Therapy
- Description:** Ischemic stroke patients prescribed antithrombotic therapy at hospital discharge.
- Denominator:** Patients with a principal diagnosis of Ischemic stroke.
- Numerator:** Patients prescribed antithrombotic therapy at hospital discharge.
- Denominator Exclusions:**
 - Exclusion 1: Patients with comfort measures documented.
 - Patients admitted for elective carotid intervention. This exclusion is implicitly modeled by only including non-elective hospitalizations.
 - Patients discharged to another hospital.
 - Patients who left against medical advice.
 - Patients who expired.
 - Patients discharged to home for hospice care.
 - Patients discharged to a health care facility for hospice care.
- Denominator Exceptions:**
 - Exception 1: Patients with a documented reason for not prescribing antithrombotic therapy at discharge.

Below this information, the user is prompted to 'Complete the following information:' and is provided with input fields for:

- Denominator 1:** 1
- Numerator 1:** 1
- Performance Rate 1 (%):** 1.00
- Exclusion 1:** 1
- Exception 1:** 1

At the bottom of the screen, there are four green buttons: **Previous**, **Next**, **Save**, and **Cancel**.

To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, Exclusion, and Exception boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

8.3.8 Clinical Quality Measure CQM105

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Clinical Quality Measures (Year 1 Attestation)

Questionnaire 8 of 16
(*) Red asterisk indicates a required field.

Measure: CMS105/NQF 0439
Versions: CMS105v3
Title: Discharged on Statin Medication
Description: Ischemic stroke patients with LDL greater than or equal to 100 mg/dL, or LDL not measured, or who were on a lipid-lowering medication prior to hospital arrival are prescribed statin medication at hospital discharge.

Denominator: Patients with a principal diagnosis of Ischemic stroke and an LDL greater than or equal to 100 mg/dL, OR LDL not measured, OR who were on a lipid-lowering medication prior to hospital arrival.

Numerator: Patients prescribed statin medication at hospital discharge.

Denominator Exclusions: Exclusion 1: Patients with comfort measures documented. Patients admitted for elective carotid intervention. This exclusion is implicitly modeled by only including non-elective hospitalizations. Patients discharged to another hospital. Patients who left against medical advice. Patients who expired. Patients discharged to home for hospice care. Patients discharged to a health care facility for hospice care.

Denominator Exceptions: Exception 1: Patients with a reason for not prescribing statin medication at discharge.

Complete the following information:

* Denominator 1: 1 * Numerator 1: 1 * Performance Rate 1 (%): 100 * Exclusion 1: 1
* Exception 1: 1

Previous **Next** **Save** **Cancel**

To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, Exclusion, and Exception boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

8.3.9 Clinical Quality Measure CQM107

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Clinical Quality Measures (Year 1 Attestation)

Questionnaire 9 of 16
(*) Red asterisk indicates a required field.

Measure: CMS107/NQF XXXX
Versions: CMS107v3
Title: Stroke Education
Description: Ischemic or hemorrhagic stroke patients or their caregivers who were given educational materials during the hospital stay addressing all of the following: activation of emergency medical system, need for follow-up after discharge, medications prescribed at discharge, risk factors for stroke, and warning signs and symptoms of stroke.

Denominator: Ischemic stroke or hemorrhagic stroke patients discharged to home, home care, or court/law enforcement.
Numerator: Ischemic or hemorrhagic stroke patients with documentation that they or their caregivers were given educational material addressing all of the following:
1. Activation of emergency medical system.
2. Follow-up after discharge.
3. Medications prescribed at discharge.
4. Risk factors for stroke.
5. Warning signs and symptoms of stroke.

Denominator Exclusions: Exclusion 1: Patients with comfort measures documented.

Complete the following information:

* Denominator 1: * Numerator 1: * Performance Rate 1 (%): * Exclusion 1:

Previous **Next** **Save** **Cancel**

To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

8.3.10 Clinical Quality Measure CQM 108

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Clinical Quality Measures (Year 1 Attestation)

Questionnaire 10 of 16
(*) Red asterisk indicates a required field.

Measure: CMS108/NQF 0371
Versions: CMS108v3
Title: Venous Thromboembolism Prophylaxis
Description: This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission.

Denominator: Patients age 18 and older discharged from hospital inpatient acute care with a diagnosis of venous thromboembolism (VTE) and a length of stay less than or equal to 120 days.
Numerator: Patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given:
The day of or the day after hospital admission.
The day of or the day after surgery end date for surgeries that start the day of or the day after hospital admission.

Denominator Exclusions:
Exclusion 1: Patients who have a length of stay less than 2 days.
Patients with comfort measures only documented anytime between arrival and the day after hospital admission.
Patients with comfort measures only documented by the day after surgery end date for surgeries that start the day of or the day after hospital admission.
Patients who are direct admits to intensive care unit (ICU), or transferred to ICU the day of or the day after hospital admission with ICU length of stay greater than or equal to one day.
Patients with a principal diagnosis of mental disorders or stroke.
Patients with a principal procedure of Surgical Care Improvement Project (SCIP) VTE selected surgeries.

Complete the following information:

* Denominator 1: 1 * Numerator 1: 1 * Performance Rate 1 (%): 1.00 * Exclusion 1: 1

Previous **Next** **Save** **Cancel**

To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

8.3.11 Clinical Quality Measure CQM109

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Questionnaire 11 of 16
(*) Red asterisk indicates a required field.

Measure: CMS109/NQF XXXX
Versions: CMS109v3

Title: Venous Thromboembolism Patients Receiving Unfractionated Heparin with Dosages/Platelet Count Monitoring by Protocol or Nomogram

Description: This measure assesses the number of patients diagnosed with confirmed VTE who received Intravenous (IV) UFH therapy dosages AND had their platelet counts monitored using defined parameters such as a nomogram or protocol.

Denominator: Patients with VTE confirmed through a diagnostic test and receiving IV UFH therapy.

Numerator: Patients who have their IV UFH therapy dosages and platelet counts monitored according to defined parameters such as a nomogram or protocol.
Patients who are on UFH therapy for less than 24 hours and have their UFH therapy dosages monitored according to defined parameters such as a nomogram or protocol.

Denominator Exclusions: Exclusion 1: Patients with comfort measures documented.
Patients discharged to another hospital.
Patients who left against medical advice.
Patients who expired.
Patients discharged to home for hospice care.
Patients discharged to a health care facility for hospice care.

Complete the following information:

* Denominator 1: 1 * Numerator 1: 1 * Performance Rate 1 (%): 1.00 * Exclusion 1: 1

Previous Next Save Cancel

To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

8.3.12 Clinical Quality Measure CQM110

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Clinical Quality Measures (Year 1 Attestation)

Questionnaire 12 of 16
(*) Red asterisk indicates a required field.

Measure: CMS110/NQF XXXX
Versions: CMS110v3

Title: Venous Thromboembolism Discharge Instructions

Description: This measure assesses the number of patients diagnosed with confirmed VTE that are discharged to home, home care, court/law enforcement or home on hospice care on warfarin with written discharge instructions that address all four criteria: compliance issues, dietary advice, follow-up monitoring, and information about the potential for adverse drug reactions/interactions.

Denominator: Patients with VTE confirmed through a diagnostic test and discharged to home or court/law enforcement on warfarin therapy.

Numerator: Patients with documentation that they or their caregivers were given written discharge instructions or other educational material about warfarin that addressed all of the following:

1. compliance issues.
2. dietary advice.
3. follow-up monitoring.
4. potential for adverse drug reactions and interactions.

Complete the following information:

* Denominator 1: 1 * Numerator 1: 1 * Performance Rate 1 (%): 100

Previous Next Save Cancel

To satisfy this CQM, enter a whole number into the Denominator, Numerator, and Performance Rate boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
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8.3.13 Clinical Quality Measure CQM111

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Clinical Quality Measures (Year 1 Attestation)

Questionnaire 13 of 16
(*) Red asterisk indicates a required field.

Measure: CMS111/NQF 0497
Versions: CMS111v3
Title: Median Admit Decision Time to ED Departure Time for Admitted Patients
Description: Median time (in minutes) from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status.

Denominator: N/A
Numerator: N/A
Denominator Exclusions: N/A
Denominator Exceptions: N/A

Complete the following information:

Stratum 1 - all patients seen in the ED and admitted as an inpatient.

* Average % of Time:
10.00

Stratum 2 - all patients seen in the ED and admitted as an inpatient who do not have a diagnosis consistent with psychiatric/mental health disorders.

* Average % of Time:
20.00

Stratum 3 - all patients seen in the ED and admitted as an inpatient who have a diagnosis consistent with psychiatric/mental health disorders.

* Average % of Time:
30.00

Previous Next Save Cancel

To satisfy this CQM, enter the average % of time for all three Stratum.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
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- Click **Save** to save selections and stay on the current screen.
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8.3.14 Clinical Quality Measure CQM113

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Clinical Quality Measures (Year 1 Attestation)

Questionnaire 14 of 16
(*) Red asterisk indicates a required field.

Measure: CMS113/NQF 0469
Versions: CMS113v3
Title: Elective Delivery
Description: Patients with elective vaginal deliveries or elective cesarean sections at ≥ 37 and < 39 weeks of gestation completed.

Denominator: Patients delivering newborns with ≥ 37 and < 39 weeks of gestation completed.
Numerator: Patients with elective deliveries with medical induction of labor or cesarean section and not in labor.
Denominator Exclusions: Exclusion 1: Patients with conditions possibly justifying elective delivery prior to 39 weeks gestation.

Complete the following information:

* Denominator 1: * Numerator 1: * Performance Rate 1 (%): * Exclusion 1:

Previous Next Save Cancel

To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

8.3.15 Clinical Quality Measure CQM114

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Clinical Quality Measures (Year 1 Attestation)

Questionnaire 15 of 16
(*) Red asterisk indicates a required field.

Measure: CMS114/NQF XXXX
Versions: CMS114v3

Title: Incidence of Potentially-Preventable Venous Thromboembolism

Description: This measure assesses the number of patients diagnosed with confirmed VTE during hospitalization (not present at admission) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date.

Denominator: Patients who developed VTE confirmed by a diagnostic test during hospitalization.

Numerator: Patients who received no VTE prophylaxis prior to the VTE diagnostic test order date.

Denominator Exclusions: Exclusion 1: Patients with comfort measures documented.
Patients with a principal diagnosis of VTE.
Patients with VTE present at admission.
Patients with reasons for not administering mechanical and pharmacologic prophylaxis.

Complete the following information:

* Denominator 1: 1 * Numerator 1: 1 * Performance Rate 1 (%): 1.00 * Exclusion 1: 1

Previous Next Save Cancel

To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

8.3.16 Clinical Quality Measure CQM190

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Clinical Quality Measures (Year 1 Attestation)

Questionnaire 16 of 16
(*) Red asterisk indicates a required field.

Measure: CMS190/NQF 0372
Versions: CMS190v3

Title: Intensive Care Unit Venous Thromboembolism Prophylaxis

Description: This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after the initial admission (or transfer) to the Intensive Care Unit (ICU) or surgery end date for surgeries that start the day of or the day after ICU admission (or transfer).

Denominator: Patients directly admitted or transferred to ICU during the hospitalization.

Numerator: Patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given:
The day of or the day after ICU admission (or transfer).
The day of or the day after surgery end date for surgeries that start the day of or the day after ICU admission (or transfer).

Denominator Exclusions: Exclusion 1: Patients who have a hospital length of stay (LOS) less than two days. Patients with comfort measures only documented during the specified date range. Patients with a principal procedure of surgical care improvement Project (SCIP) VTE selected surgeries that start the day of or the day after ICU admission or transfer.

Denominator Exceptions: Exception 1: Patients with ICU LOS less than one day without VTE prophylaxis administered and documentation for no VTE prophylaxis.

Complete the following information:

* Denominator 1: 1 * Numerator 1: 1 * Performance Rate 1 (%): 1.00 * Exclusion 1: 1

* Exception 1: 1

Previous Next Save Cancel

To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, Exclusion, and Exception boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

9 Submitting Attestation

9.1 Pre-Attestation Summary Screen

The screenshot shows the 'Pre-Attestation Summary' screen. The top header includes 'KY Medicaid EHR System', 'Cabinet for Health and Family Services', 'KY Medicaid (HHS) Incentive Program', 'Test Hospital', '0000000000', 'Logout', 'KY Agencies', 'KY Services', and 'Release: 03.28.07.03'. The sidebar on the left contains links: 'Home', 'Reports', 'Meaningful Use Questionnaire', 'Meaningful Use Memo Options', 'Meaningful Use Core Objectives', 'Meaningful Use Public Health Objectives', 'Clinical Quality Measures Submission', 'Pre-Attestation Objective Summary', 'View All Payment Years', 'Issues/Concerns', 'Appeals', 'Additional Resources', 'KY Medicaid EHR Site', 'CMS EHR Site', 'User Manuals', 'Provider User Manual', 'SP Meaningful Use Manual', and 'EP Meaningful Use Manual'. The main content area is titled 'Summary of Measures (Year 1 Attestation)' and contains a warning: 'Please select the desired measure link below to review the details of your attestation. This is your last chance to view/edit the information you have entered before you attest. Please review your information as you will be unable to edit your information after you attest.' Below this are three links: 'Meaningful Use Core Objectives Summary', 'Public Health Objectives Summary', and 'Clinical Quality Measures Summary'. At the bottom right are 'Previous' and 'Next' buttons.

The Pre-Attestation Summary allows the EH/CAH to review/edit entries made for Meaningful Use Objectives, Public Health Objectives, and Clinical Quality Measures.

- Click on a link to review the summary.

When final reviews have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.

9.1.1 Objectives Summary

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KY Medicaid EHR Incentive Program

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Test Hospital | 3000000000 | Logout | KY Agencies | KY Services

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Summary of Meaningful Use Core Measures (Year 1 Attestation)

Meaningful Use Core Measure List Table

Please select the edit link next to the measure you wish to update. If you do not wish to edit your measures you may select next to continue.

| ObjectiveText | Description | Data Entered | Selection |
|---|---|-------------------------------------|----------------------|
| Protect electronic health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities. In order to meet this objective and measures, an EH or CAH must use the capabilities and standards as defined for CEHRT at § 495.4. | Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI created or maintained by CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the eligible hospital or CAH's risk management process. | Yes | Edit |
| Implement one clinical decision support rule relevant to specialty or high clinical priority, or high priority hospital condition, along with the ability to track compliance with that rule. In order to meet this objective and measures, an EH or CAH must use the capabilities and standards as defined for CEHRT at § 495.4. | Implement one clinical decision support rule. | Yes | Edit |
| Implement one clinical decision support rule relevant to specialty or high clinical priority, or high priority hospital condition, along with the ability to track compliance with that rule. In order to meet this objective and measures, an EH or CAH must use the capabilities and standards as defined for CEHRT at § 495.4. | The eligible hospital or CAH has enabled and implemented the functionality for drug-drug and drug allergy interaction checks for the entire EHR reporting period. | Yes | Edit |
| Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional that can enter orders into the medical record per state, local, and professional guidelines. In order to meet this objective and measures, an EH or CAH must use the capabilities and standards as defined for CEHRT at § 495.4. | More than 30% of all unique patients with at least one medication in their medication list admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have at least one medication order entered using CPOE; or more than 30% of medication orders created by the authorized providers of the eligible hospital or CAH for patients admitted to their inpatient or emergency departments (POS 21 or 23) during the EHR reporting period, are recorded using computerized provider order entry. | Numerator = 30 Denominator = 100 | Edit |

| | | | |
|--|--|---|----------------------|
| <p>Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional that can enter orders into the medical record per state, local, and professional guidelines.</p> <p>In order to meet this objective and measures, an EH or CAH must use the capabilities and standards as defined for CEHRT at § 495.4.</p> | <p>More than 30% of laboratory orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.</p> | <p>Numerator = 30 Denominator = 100</p> | Edit |
| <p>Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional that can enter orders into the medical record per state, local, and professional guidelines.</p> <p>In order to meet this objective and measures, an EH or CAH must use the capabilities and standards as defined for CEHRT at § 495.4.</p> | <p>More than 30% of radiology orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.</p> | <p>Numerator = 30 Denominator = 100</p> | Edit |
| <p>Generate and transmit permissible discharge prescriptions electronically (eRx).</p> <p>In order to meet this objective and measure, an EH or CAH must use the capabilities and standards as defined for CEHRT at § 495.4.</p> | <p>More than 10% of hospital discharge medication orders for permissible prescriptions (for new and changed prescriptions) are queried for a drug formulary and transmitted electronically using CEHRT.</p> | <p>Numerator = 10 Denominator = 100</p> | Edit |
| <p>The eligible hospital or CAH who transitions a patient to another setting of care or provider of care or refers a patient to another provider of care provides a summary care record for each transition of care or referral.</p> <p>In order to meet this objective and measure, an EH or CAH must use the capabilities and standards as defined for CEHRT at § 495.4.</p> | <p>The eligible hospital or CAH that transitions or refers its patient to another setting of care or provider of care must do the following-- (1) use CEHRT to create a summary of care record; and (2) electronically transmit such summary to a receiving provider for more than 10% of transitions of care and referrals.</p> | <p>Numerator = 10 Denominator = 100</p> | Edit |
| <p>Use clinically relevant information from CEHRT to identify patient-specific education resources and provide those resources to the patient.</p> <p>In order to meet this objective and measure, an EH or CAH must use the capabilities and standards as defined for CEHRT at § 495.4.</p> | <p>More than 10% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are provided patient-specific education resources identified by CEHRT.</p> | <p>Numerator = 10 Denominator = 100</p> | Edit |

| | | | |
|---|---|---|----------------------|
| <p>The eligible hospital or CAH that receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.</p> <p>In order to meet this objective and measure, an EH or CAH must use the capabilities and standards as defined for CEHRT at § 495.4.</p> | <p>The eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).</p> | <p>Numerator = 50 Denominator = 100</p> | Edit |
| <p>Provide patients the ability to view online, download, and transmit their health information within 36 hours of hospital discharge.</p> | <p>More than 50% of all unique patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH are provided timely access to view online, download and transmit to a third party their health information.</p> | <p>Numerator = 50 Denominator = 100</p> | Edit |
| <p>Provide patients the ability to view online, download, and transmit their health information within 36 hours of hospital discharge.</p> | <p>At least 1 patient who is discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH (or patient-authorized representative) views, downloads or transmits to a third party his or her health information during the EHR reporting period.</p> | <p>Numerator = 1 Denominator = 50</p> | Edit |

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The Objectives Summary lists each Meaningful Use Objective with responses.

- If changes need to be made, click the **Edit** link for the MU Objective to update. This will redirect to the MU Objective details screen for changes to be made.

When final reviews/edits have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.

9.1.2 Public Health Objectives Summary

Kentucky.gov
Cabinet for Health and Family Services
KY Medicaid EHR Incentive Program

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Summary of Public Health Objective Measures (Year 1 Attestation)

Public Health Objective List Table

Please select the edit link next to the measure you wish to update. If you do not wish to edit your measures you may select next to continue.

| ObjectiveText | Measure | Entered | Selection |
|--|--|--|----------------------|
| The eligible hospital or CAH is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice. | The eligible hospital or CAH is in active engagement to submit data to a specialized registry. | Option 2 - Peanut Butter Option 2 - Jelly | Edit |
| We further specify that providers must use the functions and standards as defined for CEHRT at § 495.4 where applicable; however, as noted for measure 3 (Specialized Registry Reporting), providers may use functions beyond those established in CEHRT in accordance with state and local law. | | | |

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The Public Health Objectives Summary lists each Public Health Measure attested to, with responses.

- If changes need to be made, click the **Edit** link for the PH Measure to update. This will redirect to the PH Measure details screen for changes to be made.

When final reviews/edits have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.

9.1.3 Clinical Quality Measures Summary

Kentucky.gov

Cabinet for Health and Family Services

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Summary of Clinical Quality Measures (Year 1 Attestation)

Clinical Quality Measures List Table

Please select the edit link next to the measure you wish to update. If you do not wish to edit your measures you may select next to continue.

| PATIENT AND FAMILY ENGAGEMENT | | | | |
|-------------------------------|---|---|---|----------------------|
| Measure # | Title | Measure | Data Entered | Selection |
| CMS111v3/NQF 0497 | Median Admit Decision Time to ED Departure Time for Admitted Patients | Median time (in minutes) from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status. | Average Time = 50.00 Average Time = 20.00 Average Time = 2.00 | Edit |
| CMS55v3/NQF 0495 | Median Time from ED Arrival to ED Departure for Admitted ED Patients | Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department. | Average Time = 50.00 Average Time = 25.00 Average Time = 10.00 | Edit |
| CMS107v3/NQF XXXX | Stroke Education | Ischemic or hemorrhagic stroke patients or their caregivers who were given educational materials during the hospital stay addressing all of the following: activation of emergency medical system, need for follow-up after discharge, medications prescribed at discharge, risk factors for stroke, and warning signs and symptoms of stroke. | Denominator = 100 Numerator = 50 Performance Rate = 2.00 Exclusion = 2 | Edit |
| CMS110v3/NQF XXXX | Venous Thromboembolism Discharge Instructions | This measure assesses the number of patients diagnosed with confirmed VTE that are discharged to home, home care, court/law enforcement or home on hospice care on warfarin with written discharge instructions that address all four criteria: compliance issues, dietary advice, follow-up monitoring, and information about the potential for adverse drug reactions/interactions. | Denominator = 100 Numerator = 50 Performance Rate = 2.00 | Edit |

| PATIENT SAFETY | | | | |
|-------------------|---|--|---|----------------------|
| Measure # | Title | Measure | Data Entered | Selection |
| CMS114v3/NQF XXXX | Incidence of Potentially-Preventable Venous Thromboembolism | This measure assesses the number of patients diagnosed with confirmed VTE during hospitalization (not present at admission) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date. | Denominator = 100 Numerator = 50 Performance Rate = 0.00 Exclusion = 0 | Edit |

| CMS190v3/NQF 0372 | Intensive Care Unit Venous Thromboembolism Prophylaxis | This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after the initial admission (or transfer) to the Intensive Care Unit (ICU) or surgery end date for surgeries that start the day of or the day after ICU admission (or transfer). | Denominator = 100 Numerator = 50 Performance Rate = 2.00 Exclusion = 2 Exception = 2 | Edit |
|--------------------------------|---|---|---|----------------------|
| CMS108v3/NQF 0371 | Venous Thromboembolism Prophylaxis | This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission. | Denominator = 100 Numerator = 50 Performance Rate = 0.00 Exclusion = 0 | Edit |
| CARE COORDINATION | | | | |
| Measure # | Title | Measure | Data Entered | Selection |
| CMS102v3/NQF 0441 | Assessed for Rehabilitation | Ischemic or hemorrhagic stroke patients who were assessed for rehabilitation services. | Denominator = 100 Numerator = 50 Performance Rate = 2.00 Exclusion = 2 | Edit |
| CLINICAL PROCESS/EFFECTIVENESS | | | | |
| Measure # | Title | Measure | Data Entered | Selection |
| CMS71v4/NQF 0436 | Anticoagulation Therapy for Atrial Fibrillation/Flutter | Ischemic stroke patients with atrial fibrillation/flutter who are prescribed anticoagulation therapy at hospital discharge. | Denominator = 100 Numerator = 50 Performance Rate = 20.00 Exclusion = 2 Exception = 2 | Edit |
| CMS72v3/NQF 0438 | Antithrombotic Therapy by End of Hospital Day 2 | Ischemic stroke patients administered antithrombotic therapy by the end of hospital day 2. | Denominator = 100 Numerator = 50 Performance Rate = 50.00 Exclusion = 5 Exception = 5 | Edit |
| CMS104v3/NQF 0435 | Discharged on Antithrombotic Therapy | Ischemic stroke patients prescribed antithrombotic therapy at hospital discharge. | Denominator = 100 Numerator = 50 Performance Rate = 2.00 Exclusion = 2 Exception = 2 | Edit |
| CMS105v3/NQF 0439 | Discharged on Statin Medication | Ischemic stroke patients with LDL greater than or equal to 100 mg/dL, or LDL not measured, or who were on a lipid-lowering medication prior to hospital arrival are prescribed statin medication at hospital discharge. | Denominator = 100 Numerator = 50 Performance Rate = 2.00 Exclusion = 2 Exception = 2 | Edit |

| | | | | |
|-------------------|---|---|---|----------------------|
| CMS113v3/NQF 0469 | Elective Delivery | Patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed. | Denominator = 100 Numerator = 50 Performance Rate = 2.00 Exclusion = 2 | Edit |
| CMS91v4/NQF 0437 | Thrombolytic Therapy | Acute Ischemic stroke patients who arrive at this hospital within 2 hours of time last known well and for whom IV t-PA was initiated at this hospital within 3 hours of time last known well. | Denominator = 100 Numerator = 50 Performance Rate = 2.00 Exception = 2 | Edit |
| CMS109v3/NQF XXXX | Venous Thromboembolism Patients Receiving Unfractionated Heparin with Dosages/Platelet Count Monitoring by Protocol or Nomogram | This measure assesses the number of patients diagnosed with confirmed VTE who received intravenous (IV) UFH therapy dosages AND had their platelet counts monitored using defined parameters such as a nomogram or protocol. | Denominator = 100 Numerator = 50 Performance Rate = 0.00 Exclusion = 0 | Edit |
| CMS73v3/NQF 0373 | Venous Thromboembolism Patients with Anticoagulation Overlap Therapy | This measure assesses the number of patients diagnosed with confirmed VTE who received an overlap of parenteral (intravenous [IV] or subcutaneous [subcu]) anticoagulation and warfarin therapy. For patients who received less than five days of overlap therapy, they should be discharged on both medications or have a reason for discontinuation of overlap therapy. Overlap therapy should be administered for at least five days with an international normalized ratio (INR) greater than or equal to 2 prior to discontinuation of the parenteral anticoagulation therapy, discharged on both medications or have a reason for discontinuation of overlap therapy. | Denominator = 100 Numerator = 50 Performance Rate = 0.00 Exclusion = 0 | Edit |

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The Clinical Quality Measures Summary lists each Clinical Quality Measure attested to, with responses.

- If changes need to be made, click the **Edit** link for the CQM to update. This will redirect to the CQM details screen for changes to be made.

When final reviews/edits have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.

9.3 Document Upload Screen

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Cabinet for Health and Family Services
KY Medicaid EHR Incentive Program

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Document Upload (Year 2 Attestation)

Documentation needed to process your application may be attached below. If you cannot attach a PDF then use the Send E-mail link on the left to contact the EHR staff for assistance.

Required Documents for AIU & MU attesters:
1) Proof of certified technology being attested for your practice or facility. This can be: • a signed contract • a signed lease • a current invoice • a license agreement • a purchase order (PO) • or other legal documents showing that you have contracted with a certified EHR vendor for adopt, implement or upgrade.
Additional Required Documents for MU attesters:
2) KHIE on-boarding documentation.
3) Documentation on your testing with other entities as well as documentation supporting your Public Health Measure response.
4) Payment reassignment documentation if payment is assigned to any other NPI than the individual NPI.
5) Patient volume report.
If you are using Medicaid patients from multiple states you could be requested to provide additional documentation.

Please Note: Documentation loaded with the attestation does not alleviate the provider from being requested to produce additional documentation that may be requested during a pre payment or post payment audit. All documentation supporting the information attested by the Provider or Facility should be kept for 6 years.

| Payment Year | File Name | Description |
|-----------------------------|-----------|-------------|
| No uploaded document found. | | |

Upload a new PDF document:

Browse...

Upload

Please select the documentation type:

--Select the type of a document--

Previous Next

The document upload screen allows EH/CAHs to submit PDF documents as part of the attestation. This is used for supporting documentation of the attestation which includes but is not limited to patient volume report, CEHRT ID documentation, Meaningful Use report(s) from their CEHRT, and KHIE onboarding documentation.

- Select **Browse** to locate a document to upload.
- Select the documentation type from the dropdown.
- Click **Upload**.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.

9.4 Attestation Statement Screen

Kentucky.gov
Cabinet for Health and Family Services
KY Medicaid EHR Incentive Program

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Attestation Statement (Year 1 Attestation)

You are about to submit your attestation for EHR

Please check the box next to each statement below to attest, then select the **SUBMIT button to complete your attestation:**

- ☐ The information submitted for CQMs was generated as output from an identified certified EHR technology.
- ☐ The information submitted is accurate to the knowledge and belief of the official submitting on behalf of the eligible hospital or CAH.
- ☐ The information submitted is accurate and complete for numerators, denominators, and exclusions for functional measures that are applicable to the Hospital or CAH.
- ☐ The information submitted includes information on all patients to whom the measure applies.
- ☐ For CQMs, A zero was reported in the denominator of a measure when an eligible hospital or CAH did not care for any patients in the denominator population during the EHR reporting period.

I understand that I must have, and retain, documentation to support my eligibility for incentive payments and that the Department for Medicaid Services may ask for this documentation. I further understand that the Department for Medicaid Services will pursue repayment in all instances of improper or duplicate payment. I certify I am not receiving Medicaid EHR incentive funds from any other state or commonwealth and have not received a payment from the Kentucky Department for Medicaid Services for this year.

This is to certify that the foregoing information is true, accurate, and complete. I understand the Medicaid EHR incentive payments submitted under this provider number will be from Federal funds, and that any falsification, or concealment of a material fact may be prosecuted under Federal and State laws.

(*)Red asterik indicates a required field.

Initials:

NPI:

Note: Once you press the submit button below, you will not be able to change your information.

Previous **Submit**

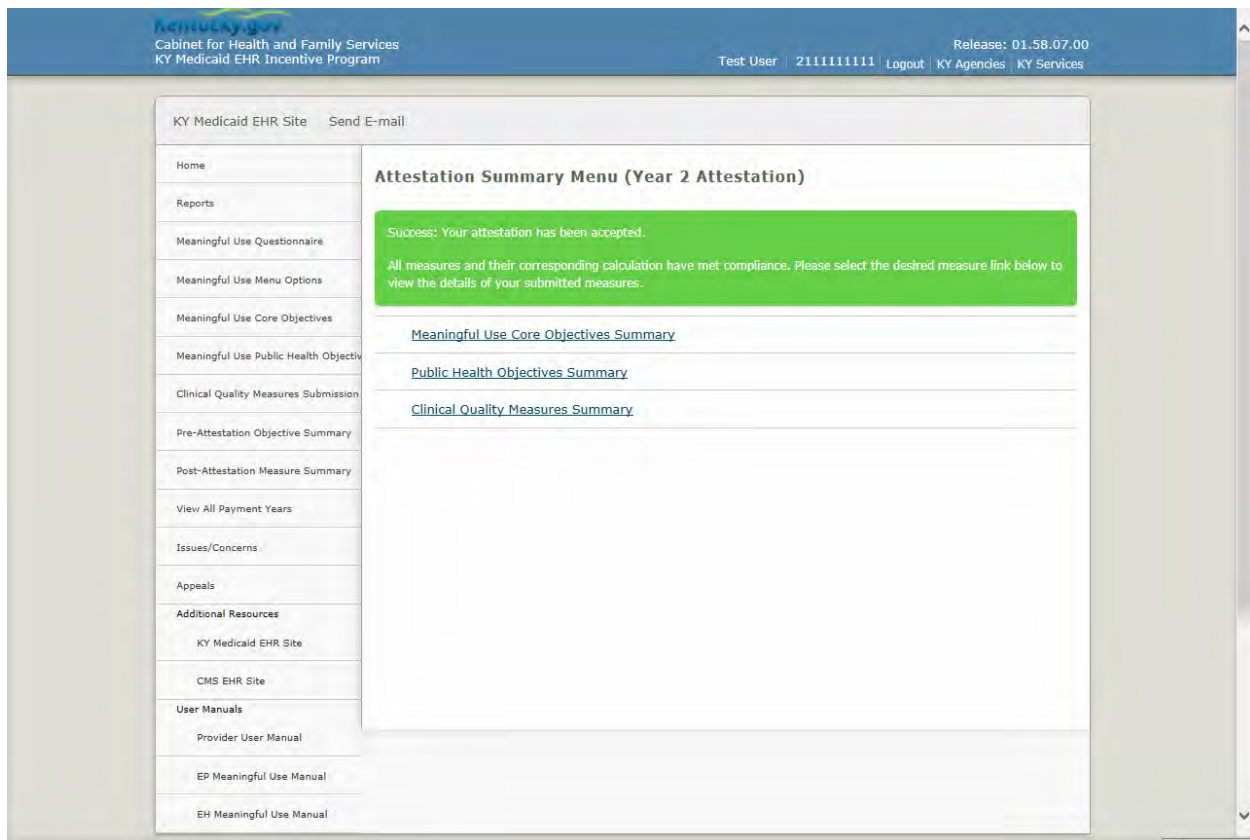
All boxes must be checked in order to submit the attestation.

Enter initials and NPI to submit the attestation.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.

9.5 Accepted Attestation Screen



Once the attestation is accepted, no updates can be made to any data from the attestation. Click on the summary links to view the measure data that was submitted and accepted for attestation.

9.6 Attestation Not Accepted Screen

The screenshot displays the Kentucky.gov website interface for the EH Meaningful Use Manual. The header includes the Kentucky.gov logo, the text 'Cabinet for Health and Family Services' and 'KY Medicaid EHR Incentive Program', and user information: 'Test User | 2111111111 | Logout | KY Agencies | KY Services'. The release date is '01.58.07.00'.

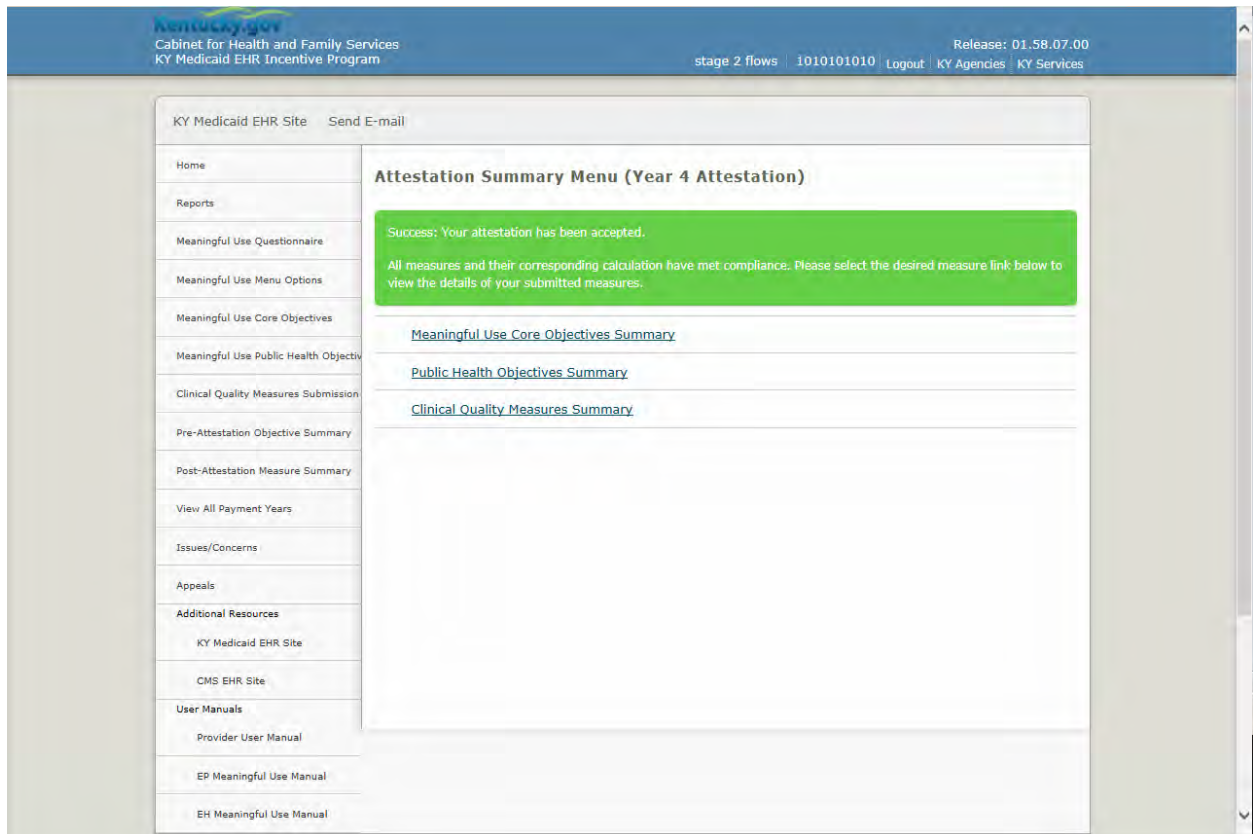
The main content area is titled 'Attestation Summary Menu (Year 2 Attestation)'. A prominent red alert box states: 'Alert: Your attestation cannot be accepted at this time. One or more of the MU Core measure calculations did not meet MU minimum standards. One or more of the Public health measures did not meet MU minimum standards. Please select the summary of measures link below to view all measures and their corresponding calculation/compliance.'

Below the alert, there are three links: [Meaningful Use Core Objectives Summary](#), [Public Health Objectives Summary](#), and [Clinical Quality Measures Summary](#).

The left sidebar contains a navigation menu with the following items: Home, Reports, Meaningful Use Questionnaire, Meaningful Use Menu Options, Meaningful Use Core Objectives, Meaningful Use Public Health Objectives, Clinical Quality Measures Submission, Pre-Attestation Objective Summary, View All Payment Years, Issues/Concerns, Appeals, Additional Resources, KY Medicaid EHR Site, CMS EHR Site, User Manuals, Provider User Manual, EP Meaningful Use Manual, and EH Meaningful Use Manual.

Click on the summary links to view the measure data responses. The summary page will indicate which measures were accepted and which were rejected.

9.7 Post Attestation Summary Screen



After attestation is completed, a statement will appear that the attestation has been accepted.

9.7.1 Objective Summary

Kentucky.gov

Cabinet for Health and Family Services
KY Medicaid EHR Incentive Program

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Meaningful Use Core Measure Summary (Year 4 Attestation)

| Objective | Measure | Entered | Status |
|--|---|---------|----------|
| Protect electronic health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities. | Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI created or maintained by CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the EP's risk management process. | Yes | Accepted |
| In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at § 495.4. | | | |
| Use clinical decision support to improve performance on high-priority health conditions. | Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions. | Yes | Accepted |
| In order to meet this objective and measures, an EP must use the capabilities and standards as defined for CEHRT at § 495.4. | | | |
| Use clinical decision support to improve performance on high-priority health conditions. | The EP has enabled and implemented the functionality for drug-drug and drug allergy interaction checks for the entire EHR reporting period. | Yes | Accepted |
| In order to meet this objective and measures, an EP must use the capabilities and standards as defined for CEHRT at § 495.4. | | | |
| Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional that can enter orders into the medical record per state, local, and professional guidelines. | More than 60% of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry. | 100% | Accepted |
| In order to meet this objective and measures, an EP must use the capabilities and standards as defined for CEHRT at § 495.4. | | | |
| Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional that can enter orders into the medical record per state, local, and professional guidelines. | More than 30% of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry. | 100% | Accepted |
| In order to meet this objective and measures, an EP must use the capabilities and standards as defined for CEHRT at § 495.4. | | | |


| | | | |
|---|--|------|----------|
| <p>Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional that can enter orders into the medical record per state, local, and professional guidelines.</p> <p>In order to meet this objective and measures, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.</p> | <p>More than 30% of radiology orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.</p> | 100% | Accepted |
| <p>Generate and transmit permissible prescriptions electronically (eRx).</p> <p>In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.</p> | <p>More than 50% of permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.</p> | 50% | Accepted |
| <p>The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.</p> <p>In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.</p> | <p>The EP that transitions or refers their patient to another setting of care or provider of care must-- (1) use CEHRT to create a summary of care record; and (2) electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals.</p> | 10% | Accepted |
| <p>Use clinically relevant information from CEHRT to identify patient-specific education resources and provide those resources to the patient.</p> <p>In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.</p> | <p>Patient-specific education resources identified by CEHRT are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period.</p> | 10% | Accepted |
| <p>The EP that receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.</p> <p>In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.</p> | <p>The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.</p> | 50% | Accepted |
| <p>Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.</p> | <p>More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely access to view online, download, and transmit to a third party their health information subject to the EP's discretion to withhold certain information.</p> | 50% | Accepted |
| <p>Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.</p> | <p>At least one patient seen by the EP during the EHR reporting period (or patient-authorized representative) views, downloads or transmits to a third party his or her health information during the EHR reporting period.</p> | 1 | Accepted |

| | | | |
|---|--|-----|----------|
| Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP. | More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely access to view online, download, and transmit to a third party their health information subject to the EP's discretion to withhold certain information. | 50% | Accepted |
| Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP. | At least one patient seen by the EP during the EHR reporting period (or patient-authorized representative) views, downloads or transmits to a third party his or her health information during the EHR reporting period. | 1 | Accepted |
| Use secure electronic messaging to communicate with patients on relevant health information. In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at § 495.4. | The capability for patients to send and receive a secure electronic message with the EP was fully enabled during the EHR reporting period. | Yes | Accepted |

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Click on the summary links to view the measure data that was submitted. The summary page will indicate which measures were accepted.

9.7.2 Public Health Objectives Summary



Cabinet for Health and Family Services
KY Medicaid EHR Incentive Program

stage 2 flows | 1010101010 | Logout | KY Agencies | KY Services

Release: 01.58.07.00

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EH Meaningful Use Manual

Public Health Measures Summary (Year 4 Attestation)

| ObjectiveText | Measure | Entered | Status |
|--|---|-------------------------------|----------|
| The EP is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice. We further specify that providers must use the functions and standards as defined for CEHRT at § 495.4 where applicable; however, as noted for measure 3, providers may use functions beyond those established in CEHRT in accordance with state and local law. | The EP is in active engagement with a public health agency to submit immunization data. | Option 3 | Accepted |
| The EP is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice. We further specify that providers must use the functions and standards as defined for CEHRT at § 495.4 where applicable; however, as noted for measure 3, providers may use functions beyond those established in CEHRT in accordance with state and local law. | The EP is in active engagement to submit data to a specialized registry. | Option 2 - KY Cancer Registry | Accepted |

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Click on the summary links to view the measure data that was submitted. The summary page will indicate which measures were accepted.

9.7.3 Clinical Quality Measures Summary

[Kentucky.gov](http://kentucky.gov)
 Cabinet for Health and Family Services
 KY Medicaid EHR Incentive Program

stage 2 flows | 1010101010 | [Logout](#) | [KY Agencies](#) | [KY Services](#)

Release: 01.58.07.00

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[KY Medicaid EHR Site](#)

[CMS EHR Site](#)

[User Manuals](#)

[Provider User Manual](#)

[EP Meaningful Use Manual](#)

[EH Meaningful Use Manual](#)

Meaningful Use Clinical Quality Measures Summary (Year 4 Attestation)

Summary of Clinical Quality Measures

| PATIENT AND FAMILY ENGAGEMENT | | |
|---|--|----------|
| Title | Description | Status |
| Oncology: Medical and Radiation - Pain Intensity Quantified | Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified. | Accepted |
| Functional Status Assessment for Knee Replacement | Percentage of patients aged 18 years and older with primary total knee arthroplasty (TKA) who completed baseline and follow-up (patient-reported) functional status assessments. | Accepted |

| PATIENT SAFETY | | |
|---|---|----------|
| Title | Description | Status |
| Falls: Screening for Future Fall Risk | Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period. | Accepted |
| Use of High-Risk Medications in the Elderly | Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported. a. Percentage of patients who were ordered at least one high-risk medication. b. Percentage of patients who were ordered at least two different high-risk medications. | Accepted |

| CARE COORDINATION | | |
|---|--|----------|
| Title | Description | Status |
| Closing the Referral Loop: Receipt of Specialist Report | Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred. | Accepted |

| POPULATION AND PUBLIC HEALTH | | |
|---|---|----------|
| Title | Description | Status |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents | Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported. Percentage of patients with height, weight, and body mass index (BMI) percentile documentation. Percentage of patients with counseling for nutrition. Percentage of patients with counseling for physical activity. | Accepted |
| Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention | Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user. | Accepted |
| Chlamydia Screening for Women | Percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period. | Accepted |
| Childhood Immunization Status | Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. | Accepted |

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Click on the summary links to view the measure data that was submitted. The summary page will indicate which measures were accepted.